



**Communities
make us**



Your group insurance plan



Contract Y9999

Management Personnel of the
Quebec Public and Parapublic Sectors

January 2022

The Intersectorial parity committee on insurances (IPC), together with SSQ, Life Insurance Company Inc., is pleased to present this booklet describing the main features of the benefits available to you under the group insurance plan for management personnel of the Quebec public and parapublic sectors.

This booklet is divided into two sections. The first (grey pages) briefly describes the plans self-insured by the Quebec government that are part of your working conditions. The second describes the group insurance plans underwritten by SSQ that round out the Quebec government's self-insured plans.

Please read this booklet carefully. It describes the benefits you are entitled to. If you have any questions concerning your insurance, contact the personnel department of the organization where you work.

This document has been prepared for information purposes only and has no contractual value. The insurance contracts alone can be used to settle legal questions.

You will find the composition of the IPC and contact information at the end of this booklet.

In this document, the masculine gender is used only to facilitate reading and has no discriminatory intent.



To contact SSQ

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Quebec city area: 418 651-6962
Other areas: 1 888 833-6962

ssq.ca

This booklet described your group insurance plan effective January 1, 2022. It is only available in electronic version on the **Customer Centre** at customer-centre.ssq.ca.

Please note that in this booklet, the name SSQ is used to designate SSQ, Life Insurance Company Inc.

Cette brochure est disponible en français.

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SUMMARY OF BENEFITS

Customary and reasonable expenses: to be eligible, the expenses incurred for services or supplies must meet the reasonable standards of the common practice of the health professionals involved.

| Benefit | Reimbursement limitations | Prescription required | Percentage reimbursed |
|--|---|---------------------------------|-----------------------|
| COMPULSORY BASIC ACCIDENT AND HEALTH INSURANCE PLAN | | | |
| Travel Insurance with Assistance | Maximum reimbursement of \$5,000,000 / trip / insured If you plan to travel more than 180 days a year, you must contact SSQ in advance for information about applicable conditions. | YES | |
| Trip Cancellation Insurance | Maximum reimbursement of \$5,000 / trip / insured, with evidence deemed satisfactory by SSQ | N/A | |
| Hospital expenses in Quebec | Semi-private room, no limit on number of days | NO | |
| Medical expenses outside Quebec | Three (3) times the amount paid by the RAMQ * | Prior authorization by the RAMQ | 100% |
| Hospital expenses outside Quebec | One (1) time the amount paid by the RAMQ | Prior authorization by the RAMQ | |
| Transportation and accommodation fees outside Quebec | Maximum reimbursement of \$5,000 / calendar year / insured | Prior authorization by the RAMQ | |

* Régie de l'assurance maladie du Québec

| Benefit | Reimbursement limitations | Prescription required | Percentage reimbursed |
|--|--|-----------------------|--|
| Prescription drugs and eligible pharmaceutical services | Drugs available only by prescription Mandatory generic substitution | YES | |
| Home care: | Within 30 days of a hospitalization | YES | |
| - Nursing care | Eligible expenses of \$60 / day / insured | YES | |
| - Transportation expenses | Eligible expenses of \$30 / trip / maximum of 3 trips / week / insured | YES | |
| - Convalescent home | Eligible expenses of \$125 / day / insured | YES | |
| - Home assistance services | Eligible expenses of \$60 / day / insured | YES | |
| - Childcare expenses | Eligible excess expenses of \$25 / day / child | YES | |
| Wheelchair - hospital bed | Temporary use only | YES | 75% on the first \$3,000, 100% of subsequent amounts |
| Artificial limbs and external prostheses | Customary and reasonable expenses | YES | |
| Wig (following chemotherapy) | Maximum reimbursement of one (1) wig and \$500 / 48 months / insured | YES | |
| Intraocular lenses | Customary and reasonable expenses | YES | |
| Breast prostheses (following a mastectomy) | Customary and reasonable expenses | YES | |
| Surgical brassieres (following a mastectomy or breast reduction) | Customary and reasonable expenses | YES | |

| Benefit | Reimbursement limitations | Prescription required | Percentage reimbursed |
|---|---|-----------------------|--|
| Trusses, bandages, corsets, crutches, splints, casts, orthotic shoe inserts (specialized laboratory) and other orthoses | Customary and reasonable expenses | YES | 75% on the first \$3,000, 100% on subsequent amounts |
| Blood glucose monitor | Eligible expenses of \$300 / 36 months / insured | YES | |
| Therapeutic devices | Customary and reasonable expenses | YES | |
| Insulin pump | Purchase and maintenance of the pump: Maximum reimbursement of \$7,500 / 60 months / insured | YES | |
| | Items needed to operate the pump: Maximum reimbursement of \$4,000 / calendar year / insured | | |
| Percutaneous or transcutaneous electrical nerve stimulator (PENS/ TENS) | Eligible expenses of \$1,000 / 60 months / insured | YES | |
| Orthopaedic shoes (specialized laboratory) | Customary and reasonable expenses | YES | |
| Electrocardiograms, X-rays (including scanner), magnetic resonance, ultrasounds and laboratory analyses | Customary and reasonable expenses | YES | |
| Respirators and oxygen | Customary and reasonable expenses | YES | |
| Hearing aids | Eligible expenses of \$1,000 / 48 months / insured | NO | |

| Benefit | Reimbursement limitations | Prescription required | Percentage reimbursed |
|--|--|-----------------------|--|
| Nurse | Customary and reasonable expenses | YES | |
| Cosmetic surgery | Following an accident | YES | |
| Support stockings | 21 mm Hg or more, three (3) pairs / calendar year / insured | YES | |
| Sclerosing injections | Substance: Eligible expenses of \$20 / treatment / day / insured Professional fees: Eligible expenses of \$25 / treatment / day / insured | NO | 75% on the first \$3,000, 100% on subsequent amounts |
| Dental surgery following an accident | Treatment received during the 12 months following the accident | NO | |
| Ambulance | Customary and reasonable expenses | NO | |
| Preventive or curative vaccines | Eligible expenses of \$200 / calendar year / insured | NO | |
| Transportation and accommodation in Quebec | Maximum reimbursement of \$1,000 / calendar year / insured | YES | |
| Detoxification treatment | Eligible expenses of \$50 / day, maximum of 30 days / calendar year / insured , in a recognized establishment | YES | |
| Optometrist or ophthalmologist | Maximum reimbursement of \$50 / 24 months / insured | NO | |

COMPULSORY BASIC ACCIDENT AND HEALTH INSURANCE PLAN - Professional fees

| Grouping | Eligible expenses per treatment | Maximum reimbursement per calendar year, per insured and group | Percentage reimbursed |
|--|-----------------------------------|--|--|
| Dietitian | \$30 | \$500 | |
| Naturopath | \$30 | | |
| Homeopath | \$30 | \$600 | |
| Phytotherapist | \$30 | | |
| Acupuncturist | \$30 | | |
| Osteopath | \$30 | | |
| Kinesitherapist | \$30 | \$600 | |
| Orthotherapist | \$30 | | |
| Massage therapist | \$30 | | |
| Chiropractor* | \$30 | \$500 | |
| Physiotherapist, Physical rehabilitation therapist, Certified athletic therapist | \$40 | Unlimited | 75% on the first \$3,000, 100% on subsequent amounts |
| Audiologist | \$60 | | |
| Hearing aid specialist | \$40 | \$500 | |
| Occupational therapist | \$40 | \$500 | |
| Speech language pathologist | \$60 | \$600 | |
| Podiatrist | \$40 | \$500 | |
| Psychiatrist, Psychoanalyst, Psychologist, Psychotherapist Social worker Marital and family therapist Career counsellor | Customary and reasonable expenses | \$1,000 | |

No medical prescription is required for reimbursement of the professional fees indicated in the above table.

* Fees for X-rays taken in a chiropractor's office are limited to \$50 / year, subject to a \$500 maximum reimbursement per calendar year, per insured.

| | |
|--|--|
| COMPULSORY BASIC LIFE INSURANCE PLAN | |
| - Participant's Basic Life Insurance: | 50% of salary |
| - Spouse's Life Insurance: | \$17,200 |
| - Dependent Children's Life Insurance: | \$5,000 / child |
| - Participant's, Spouse's and Dependent Children's Accidental Dismemberment Insurance | |
| PARTICIPANT'S AND SPOUSE'S OPTIONAL LIFE INSURANCE PLAN | |
| - Participant's Optional Life Insurance: | 1, 2, 3, 4 or 5 times annual earnings |
| - Spouse's Optional Life Insurance: | In increments of \$10,000, maximum \$100,000 |
| <i>Evidence of insurability may be required in accordance with section 5 of this booklet</i> | |
| COMPULSORY BASIC LONG TERM DISABILITY INSURANCE PLAN | |
| 65% of gross monthly earnings as of the 105 th week of total disability | |
| COMPULSORY ADDITIONAL LONG TERM DISABILITY INSURANCE PLAN (CAP) | |
| Supplementary income that complements, in part, the income received from rehabilitation employment | |

Please refer to the text in the booklet for specific details concerning each benefit and applicable exclusions and limitations.

PLANS SELF-INSURED BY THE QUEBEC GOVERNMENT:

- UNIFORM LIFE INSURANCE PLAN**
- SURVIVOR'S PENSION PLAN**
- SHORT TERM DISABILITY INSURANCE PLAN**

The Quebec government covers these plans for management personnel of the Quebec public and parapublic sectors. You pay no premiums under these plans.

Please note that this document has been prepared for information purposes only and has no legal value. Only the full texts approved by the appropriate authorities can be used to specifically determine the benefits of these plans and how they apply and, if required, settle any dispute concerning these plans.

Contact your employer for further information.

I- UNIFORM LIFE INSURANCE PLAN

A- Benefit

Management personnel benefit from life insurance coverage of \$6,400, payable to the legatees designated in a will or, failing that, to the heirs as defined in the Civil Code. This amount is reduced to \$3,200 for participants working part time.

B- Death benefit claim

To obtain payment of the amount of coverage provided by the Quebec government, the heirs must complete the *Application for a survivor's benefit* form available from their employer or from Retraite Québec. The form must be sent to:

Retraite Québec
P.O. Box 5500, Stn Terminus
Quebec (Quebec) G1K 0G9

II- SURVIVOR'S PENSION PLAN

Survivor's pensions are payable monthly, starting on the first day of the month during which a participant with a spouse or dependent children dies.

A- Spouse's pension

This pension is payable to the spouse, as defined in the *1-General Information* section, until his or her death.

- The survivor's pension will be paid to the spouse as named by the participant to SSQ. Any change of spouse should be made in writing by the participant to SSQ through his employer.

The initial amount of the pension is equal to 40% of the participant's monthly earnings and is reduced by the initial amount of the similar pension payable under the Quebec Pension Plan.

B- Dependent children's pension

This pension is payable to the dependent children, as defined in the *1-General Information* section, or to their guardian.

When a spouse's pension is payable, the initial amount of the dependent children's pension is equal to 15% of monthly earnings for all of the dependent children combined.

If there is no spouse or if the spouse who had been receiving a pension dies, the initial amount of the dependent children's pension is equal to 15% of monthly earnings for the first dependent child and to 10% of the same earnings for each additional dependent child.

However, the initial amount of the pensions payable to the spouse and dependent children can never exceed 55% of the participant's monthly earnings at the time of his death.

C- Earnings used to calculate the pension

These pensions are based on the participant's monthly earnings at the time of his death and, if applicable, on the Compulsory Additional Long Term Disability Insurance Plan (CAP).

If a participant is totally disabled at the time of his death, pensions are calculated in accordance with the earnings on which the short term disability benefit is based or, if the disability has lasted for more than 104 weeks, in accordance with the insurable earnings on which calculation of the Long Term Disability Benefit is based.

D- Survivor's pension claims

All requests for survivor's pension payments must be sent in writing to SSQ.

E- Exemption

A participant who does not have a spouse or dependent children and who provides evidence that no benefits will be payable under the survivor's pension plan may be exempted from participation in this plan during the following periods:

- 1- unpaid absence or leave for more than 30 days; or
- 2- period not worked at the time of an unpaid partial leave that is spread out over a period of more than 30 days; or

- 3- period not worked within the context of an agreement of reduced working time; or
- 4- non-rehiring, termination of employment or dismissal contested by appeal.

The participant must file his request for exemption with his employer under the circumstances described in items 1, 2 and 3 before the leave starts, or with SSQ under the circumstance described under item 4, at the time of submitting his request for maintaining the insured plans for the duration of this appeal.

Under the circumstances described above, the participant must use the form entitled *Request for exemption of participation in the survivor's pension plan* that can be obtained from his employer.

III- SHORT TERM DISABILITY INSURANCE PLAN

This plan covers the first 104 weeks of disability for management personnel. Your employer is responsible for paying the benefits under this plan.

A- Disability

Total disability is defined as a state of incapacity resulting from illness, accident or serious complications arising from pregnancy or from a surgical procedure directly related to family planning requiring medical care, and rendering the employee totally incapable of carrying out the usual duties of his employment or any other employment with similar remuneration offered to him by the employer.

No total disability period is recognized if resulting from self-inflicted injury or illness, alcoholism or drug addiction, active duty in the armed forces or active participation in a riot, insurrection, offences or criminal acts.

In the case of alcoholism or drug addiction, a total disability period is recognized if during such period, the employee receives treatment or medical care with a view to rehabilitation.

B- Benefits under the plan

First period

During the first week of total disability, the participant receives the earnings he would have been entitled to had he been at work.

Second period

From the second week of total disability to the 26th week from the onset of the disability, the disability insurance benefit is equal to 80% of the earnings the participant would have been entitled to had he been at work.

Third period

From the 27th week of total disability up to the 104th week from the onset of the disability, the disability insurance benefit is equal to 70% of the earnings the participant would have been entitled to had he been at work.

- For a participant whose rehabilitation started during the first 104 weeks of the disability, benefits are equal to 90% of the employee's earnings for the working period provided for in the rehabilitation plan.

C- Coordination of benefits

The amount of the benefits payable under the short term disability insurance plan is reduced by any disability benefits payable under the Quebec Automobile Insurance Act, the Quebec Pension Plan, the Act respecting industrial accidents and occupational diseases and any other pension plan to which the employer contributes.

PLANS INSURED BY SSO

1- GENERAL INFORMATION: INSURED PLANS

1.1 ELIGIBILITY

The employer determines, based on sectoral working conditions policies, which employees are eligible for insurance.

Employees whose work week is equal to or less than 25% of the regular work week of a full time employee, as well as those who participate in the Retired Management Personnel of the Quebec Public and Parapublic Sectors or who receive a pension administered by Retraite Québec (except for the Régime de retraite des élus municipaux (RREM), the Régime de retraite des maires et des conseillers des municipalités (RRMCM) and the Régime de retraite des membres de l'Assemblée nationale (RRMAN)) are not eligible for this group insurance plan.

Provided the employee is at work, participation in the plan begins:

- one (1) month after the date he began employment as a full-time employee;
- three (3) months after the date he began employment as a part-time employee.

The above-mentioned waiting periods do not apply to any individual who had been working for an employer in the Quebec public and parapublic sectors in the 30 days prior to his date of employment.

1.2 PARTICIPATION IN THE GROUP INSURANCE PLAN

All eligible employees must participate in the Compulsory Basic Accident and Health Insurance Plan, the Compulsory Basic Life Insurance Plan and the Compulsory Long Term Disability Insurance plans.

Under Quebec's Act respecting prescription drug insurance, the participant must cover his spouse, dependent children, and any persons suffering from a functional impairment, if applicable, for prescription drugs coverage. As this coverage is part of the Compulsory Basic Accident and Health Insurance Plan, coverage under this plan should comply with statutory requirements governing this matter.

Participant aged 65 or over

The participant is automatically registered for the Régie de l'assurance maladie du Québec (RAMQ) upon reaching age 65, and must choose one of the following options:

- Opt out of the RAMQ plan and maintain full coverage (including prescription drugs insurance) under this Accident and Health Insurance Plan for himself, his spouse, their dependent children and persons suffering from a functional impairment by paying the additional premium required;
- Maintain registration to the RAMQ prescription drugs coverage for himself, his spouse, their dependent children and persons suffering from a functional impairment, and maintain coverage for the other benefits under this Accident and Health Insurance Plan;

Participant age 65 and over who maintain their registration to the RAMQ prescription drug coverage file their prescription drugs claims with this public plan. The amount paid by the participant is considered an eligible expense under the “drugs” coverage. Participant cannot change their mind at a later date and return to the prescription drugs insurance coverage under the SSQ plan. The choice is irrevocable.

Participant age 65 or over who do not wish to be covered under the RAMQ continue to file their prescription drugs claims with SSQ. They must submit their claims to SSQ in writing and pay the additional premium (per period of 14 days) indicated in the table of premiums shown at the end of this booklet.

Unless otherwise indicated by the participant, SSQ prescription drugs insurance ends on the first pay period following the participant's 65th birthday.

Spouse who reaches age 65 before the participant

If the spouse turns age 65 before the participant, the spouse has the choice of maintaining prescription drugs insurance with SSQ or registering with the RAMQ.

Unless instructions to the contrary are received, SSQ and the RAMQ will automatically assume that a spouse turning age 65 is registered for RAMQ's Public Prescription Drug Insurance Plan. The following table explains how to inform SSQ of the spouse's choice upon turning 65:

| Spouse remains insured with SSQ for prescription drugs | Spouse is insured with RAMQ for prescription drugs |
|--|---|
| <ul style="list-style-type: none"> Registration to the RAMQ happens automatically upon reaching age 65. The RAMQ will therefore have to be informed that the spouse wishes to opt out of the Public Prescription Drug Insurance Plan upon turning age 65. | <ul style="list-style-type: none"> Registration to the RAMQ happens automatically upon reaching age 65. No particular action needs to be taken in relation to the RAMQ. |
| <ul style="list-style-type: none"> The participant will have to inform SSQ of the spouse's decision. SSQ will maintain the spouse's prescription drugs coverage as well as other coverage held under the Basic Accident and Health Insurance Plan. | <ul style="list-style-type: none"> No particular action needs to be taken in relation to SSQ. SSQ will maintain the spouse's other coverage under the Basic Accident and Health Insurance Plan, including prescription drugs not covered under the public plan that are eligible for reimbursement by SSQ. In addition, the required amount paid by the spouse (deductible and coinsurance) under the public plan is considered an eligible expense under SSQ's prescription drug provision. |

| Spouse remains insured with SSQ for prescription drugs | Spouse is insured with RAMQ for prescription drugs |
|--|---|
| <ul style="list-style-type: none"> • The participant pays the family premium for the Compulsory Basic Accident and Health Insurance Plan. • No additional premium will be applicable to SSQ coverage for a spouse aged 65 or over. | <ul style="list-style-type: none"> • The participant pays the family premium for the Compulsory Basic Accident and Health Insurance Plan. • The public plan premium must be paid the next time the spouse files an income tax report. |
| <ul style="list-style-type: none"> • This decision is revocable. The spouse may register for the public plan at any time. | <ul style="list-style-type: none"> • The decision to register for the public plan is irrevocable. The spouse will no longer be able to be insured by SSQ for prescription drugs covered under the RAMQ's public plan. |

As the Compulsory Basic Accident and Health Insurance Plan does not charge an additional premium for spouses aged 65 or over, the best choice is for the spouse to maintain his prescription drugs insurance coverage with SSQ.

1.3 EXEMPTION AND TERMINATION OF THE EXEMPTION ENTITLEMENT

Upon presentation of proof of coverage under another group insurance contract providing drug coverage, a participant may be exempted from participation in this plan. However, he must participate in the other compulsory plans (Life and Disability), and may choose to participate in the Optional Life Insurance Plan.

Participants who wish to take advantage of this option must submit such request to SSQ through the employer. The exemption becomes effective on the date the request is received by the employer and the premium is modified as of the first day of the pay period following or coinciding with this date.

An exempted participant may resume participation in the Compulsory Basic Accident and Health Insurance Plan (Individual, Single-Parent or Family coverage status) without evidence of insurability being required, provided the request is made to SSQ via the employer within **60 days** following termination of the insurance that allowed the participant to be exempted. The insurance then takes effect as of the date of termination of the exemption and the premium is payable as of the first day of the pay period following or coinciding with this date.

After this 60-day period, coverage takes effect on the first day of the pay period following or coinciding with the date on which the request is received by SSQ.

1.4 PARTICIPANT

An employee accepted for insurance and who pays the required premiums.

1.5 INSURED

The persons insured are the participant himself, his spouse, their dependent children and any persons suffering from a functional impairment, in accordance with Quebec's Act respecting prescription drug insurance.

1.5.1 Spouse

A person who became related to the participant following a marriage or civil union contracted legally and recognized as valid by Quebec law or a person who is presented publicly as the participant's spouse and who has been residing permanently with the participant for more than one (1) year, or is residing with the participant if a child is born of their union.

The dissolution of a marriage by divorce or the annulment of a marriage or civil union cancels the status of spouse, as does a de facto separation for more than three (3) months in the case of a union not contracted legally.

When the participant is legally united to another person through marriage or civil union, he may designate to SSQ some other person as the spouse in lieu of the legal spouse, providing that the designated spouse is covered under the definition of a common-law spouse provided above. The designation of this person takes effect on the date SSQ is notified.

1.5.2 Dependent children

A dependent child is a child of the participant, of the participant's spouse or of both, or a child of whom the participant has legal custody or had legal custody when the child became of age or that he had then de facto adopted, who is neither married nor civilly united and dependent on the participant for support and who:

- is under age 18; or
- is under age 26, if a full-time student in an accredited educational institution.

A declaration of school attendance must be provided to SSQ via the Customer Centre Web site or by telephone or in writing, once every school year (September 1 to August 31) for prescription drugs claims to be accepted directly at the pharmacy. SSQ reserves the right to require proof of school attendance; or

- regardless of age, became fully disabled while meeting one of the previous criteria and remained continually disabled since that time.

Quebec's Act respecting prescription insurance **requires** parents who have access to a group insurance plan to cover their dependent children, independently of whether or not they have legal custody, in the case of divorce for example. If both parents are eligible for a group insurance plan, they must reach an agreement between themselves.

Leave from studies for dependent children

For the purposes of the Compulsory Basic Accident and Health Insurance and Compulsory Basic Life Insurance plans, a dependent child who takes an extended leave from studies may retain the status of a dependent so long as he satisfies the following conditions:

- prior to the leave, a written request must be submitted to and accepted by SSQ before the leave begins;
- the request must indicate the date the leave is to begin along with its duration;
- for each dependent there is a single lifetime entitlement to such a leave;
- the leave may not exceed 12 months, subject to eligibility for the RAMQ, and must end at the beginning of a school year or term (September or January);
- the eligible expenses incurred during such leave may not exceed \$1,000,000.

1.5.3 Persons suffering from a functional impairment

A person of age, with no spouse, suffering from a functional impairment as defined in the Regulation respecting the basic prescription drug insurance plan and which occurred while he met the definition of "dependent" under the contract, who is not receiving benefits under a last resort financial assistance program under the Act respecting income support, employment assistance and social solidarity, is living with the participant and over whom the participant or the participant's spouse would exercise parental control if he were a minor.

A person suffering from a functional impairment can only be covered under the Compulsory Basic Accident and Health Insurance Plan.

1.6 BENEFICIARY

A person designated by the participant to whom the amount insured will be paid upon the death of the participant. In the absence of a designated beneficiary, the insured sum is paid to the participant's estate.

Benefits payable on the death of the insured spouse or dependent child are always payable to the participant.

The participant may change beneficiary within the limits provided by law via the **Customer Centre** Web site or by notifying SSQ's Head Office in writing.

1.7 INDIVIDUAL, SINGLE-PARENT OR FAMILY COVERAGE STATUS

One of the following options must be selected for the Compulsory Basic Accident and Health Insurance Plan:

- **Individual** coverage status (covers the participant only);
- **Single-Parent** coverage status (covers the participant, his/her dependent children and person suffering from a functional impairment);
- **Family** coverage status (covers the participant, spouse, their dependent children and person suffering from a functional impairment).

This is an important choice, since the premium payable depends directly on the coverage status chosen. This choice does not affect the other available plans (such as the Spouse's and Dependent Children's Life Insurance Plan provided under the Compulsory Basic Life Insurance Plan described in *Section 4* and the survivor's pension described in *Section II*).

1.8 CHANGES TO COVERAGE STATUS

1.8.1 Increase in coverage status

Coverage status can be increased by changing from **Individual** coverage to **Single-Parent** or **Family** coverage, or by changing **Single-Parent** coverage to **Family** coverage.

Any increase in coverage status for the **Compulsory Basic Accident and Health Insurance Plan** is subject to the following conditions:

- a) when a request for Single-Parent coverage status is submitted to the employer within 60 days following the birth or adoption of a child or within 60 days following termination of insurance for dependent children under another group insurance plan with similar coverage:
 - Single-Parent coverage status takes effect retroactive to the date of birth or adoption or termination of insurance.
- b) when a request for Family coverage status is submitted to the employer within 60 days following the marriage, acknowledgment of a common-law spouse or termination of the spouse's insurance:
 - Family coverage status takes effect retroactive to the date of the event.
- c) when the request for a Single-Parent or Family coverage status is submitted after the periods mentioned in paragraphs a) and b):
 - the requested coverage status takes effect on the date the request is received by SSQ and the premium is payable on the first day of the pay period that follows or that coincides with the date on which the request is received by SSQ.

Upon the birth or adoption of a dependent child, such child is automatically insured if the participant already holds Single-Parent or Family coverage.

1.8.2 Reduction in coverage status

Coverage status can be reduced by changing **Family** coverage to **Single-Parent** or **Individual** coverage, or by changing **Single-Parent** coverage to **Individual** coverage.

However, under Quebec's Act respecting prescription drug insurance, the participant must cover his spouse, dependent children, and any persons suffering from a functional impairment, if applicable, for prescription drugs coverage. As this coverage is part of the Compulsory Basic Accident and Health Insurance Plan, coverage under this plan should comply with statutory requirements governing this matter.

The coverage status requested becomes effective as of the date the request is received by the employer and the premium is payable as of the first day of the pay period coinciding with or following this date.

1.8.3 Request for a change

For any request to change coverage status, the participant must submit such request to SSQ through the employer.

1.9 SMOKER/NON-SMOKER STATUS

The premium rates for Optional Life Insurance provide for a premium reduction for a participant or spouse who is a non-smoker.

To benefit from this reduction, the participant must sign the non-smoker declaration provided. This declaration may be obtained from the employer's human resources department. **Any false declaration may lead to cancellation of coverage.**

To be considered a non-smoker, the person must not have smoked any tobacco products such as cigarettes, electronic cigarettes (vaping device), cigars, cigarillos or pipes, nor any drugs, during the previous 12 months.

If the participant or his spouse ceases to meet the required conditions, SSQ must be notified in order to correct the case file and premium accordingly.

In each case, a new certificate is issued confirming the status of smoker or non-smoker.

1.10 EARNINGS

Earnings used for insurance purposes are determined in accordance with working conditions.

In the event of total disability, the annual earnings used for insurance purposes are those used for the calculation of benefit payments under the employer's short term disability insurance plan. If the disability lasts more than 104 weeks, the earnings used are the gross earnings at the end of the first 104 weeks of total disability, indexed in accordance with the rules defined in *Section 6.8* of this booklet.

1.11 MAINTAINING INSURANCE WITHOUT PAYMENT OF PREMIUMS AND WAIVER OF PREMIUMS

Any participant who becomes totally disabled remains covered under the compulsory and optional plans without payment of premiums as of the 2nd week of disability and for the duration of his disability.

However, any participant who is totally disabled who takes paid early retirement leave may not benefit from the waiver of premiums during this leave.

In addition, a participant may not benefit from a waiver of premiums during CNESST-approved preventive maternity leave.

1.12 TEMPORARY ABSENCE FROM WORK

1.12.1 Leave without pay or unpaid leave - 30 days or less

All of the participant's coverage is automatically maintained in force and the applicable premiums (employee and employer share) continue to be paid to SSQ in the usual manner.

1.12.2 Leave without pay or any other full-time unpaid leave - More than 30 days

In the case of a leave without pay or full-time unpaid leave (**including suspension**) of more than 30 days, the participant must maintain his participation in the Compulsory Basic Accident and Health Plans and pay the entire premiums (employee and employer share). Participation in the other insurance plans is automatically suspended. However, if the participant wishes, he may maintain coverage under the other plans **by assuming full payment for all premiums (employee and employer share)** based on the earnings he was receiving immediately before the beginning of his absence.

For a participant who maintains coverage in force, and who then becomes disabled, the disability is considered to have started on the date of the end of the absence or leave.

1.12.3 Partial leave or any other partial unpaid leave of more than 30 days, including for the public sector, the reduction in work time of more than 30 days

Participation in the Compulsory Basic Accident and Health Insurance Plan continues as if the participant were working full time. The participant and the employer assume their respective portions of the premiums for this plan.

Participation in Life Insurance (Compulsory Basic and Optional), Long Term Disability Insurance (Compulsory Basic and CAP), and survivor's pensions, continues based on the time worked and according to the coverage held immediately before the leave or agreement.

The participant can maintain coverage under these plans based on the time normally worked prior to the beginning of the leave or agreement.

In such a case, he must assume full payment for all premiums (employee and employer share) for the portion of time not worked.

1.12.4 Maternity leave (paid)

All of the participant's coverage is maintained in force without payment of premiums by the participant during the period prescribed by the maternity leave described in the working conditions.

1.12.5 Leave for a birth or a paternity or adoption leave (paid)

All of the participant's coverage is automatically maintained in force and the applicable premiums (employee and employer share) continue to be paid to SSQ.

Any disability that begins during the period of leave is deemed to have begun on the date of the end of the leave for a birth or paternity or adoption leave.

1.12.6 Parental leave (unpaid)

During an unpaid parental leave, participation in the Compulsory Basic Accident and Health Insurance is maintained in force for the duration of the leave.

Coverage under the other insurance plans is as follows.

In the case of unpaid parental leave;

- a) of a maximum of 2 years immediately following the maternity, paternity or adoption leave; or
- b) no more than 52 continuous weeks that must end no later than 70 weeks after the birth or, in the case of an adoption, within 70 weeks after the child has been given over to the participant;

in the case of a full-time unpaid leave, the participant must choose one of the following options:

1. maintain participation in all plans. The premiums are based on the pay the participant would receive if he were working and all provisions apply. The choice to suspend or maintain participation in these plans must be indicated before the leave starts. SSQ may refuse any request received more than 30 days after the beginning of this type of leave. The choice to suspend participation is irrevocable. The choice to maintain participation may be cancelled by the participant during the leave.

In the case of any disability period beginning while the participant is insured during an unpaid parental leave, the waiting period for the Compulsory Basic Long Term Disability Insurance Plan and the Compulsory Additional Long Term Disability Insurance Plan is deemed to start on the date of the end of the participant's leave.

2. maintain his coverage under only the Compulsory Basic Accident and Health Insurance Plan for the duration of the leave.

During the first 52 weeks of the full-time unpaid parental leave, the employer and participant pay their respective premiums.

In the case in paragraph a), after the 52nd week, the participant pays both premiums (employee and employer share).

in the case of an unpaid partial leave, the participant must choose one of the following options:

1. maintain participation in all plans he is participating in before the beginning of the leave, based on the time normally worked before the leave. Premiums are based on the earnings the participant would receive if at work and all provisions of the plans apply.

During the first 52 weeks of an unpaid partial leave, the employer and participant pay their respective premiums.

After the 52nd week of the unpaid partial leave, the employer and employee pay their respective share of the premiums, for the days worked by the participant, and the participant pays both premiums (employee and employer share), for the unworked days;

2. maintain participation in all plans he is participating in before the beginning of the leave, based on the time worked during the unpaid partial leave. Premiums are based on the salary received during the unpaid partial leave. During the leave, the employer and participant pay their respective share of the latter premiums.

1.12.7 Certain unpaid leaves provided for under sections V.0.1 and V.1 of the Act Respecting Labour Standards

In the case of certain unpaid leaves provided for under sections V.0.1 and V.1 of the Act Respecting Labour Standards, participation in the Compulsory Basic Accident and Health Insurance Plan is maintained for the duration of the leave.

Coverage under the other insurance plans is as follows

In the case of an unpaid absence up to the maximum duration provided for under the Act Respecting Labour Standards the participant must choose one of the following options.

1. maintain participation in all plans. Choosing to suspend or maintain participation in these plans must be reported at the beginning of the leave. SSQ may refuse any request it receives more than 30 days after the beginning of such a period of absence. The choice to suspend participation is irrevocable. The choice to maintain participation may be cancelled by the participant during the period of absence.

In the case of any period of disability beginning while the participant is insured during an unpaid period of absence, the waiting period for the Compulsory Basic Long Term Disability Insurance Plan and the Compulsory Additional Long Term Disability Insurance Plan is deemed to start on the date of the employee's absence ends.

2. maintain in force only his coverage under the Compulsory Basic Accident and Health Insurance for the duration of the absence. In such a case, the employee's other coverage resumes automatically when he returns to paid work. This provision applies automatically to any participant who has not asked to have his coverage maintained according to the terms described in the previous point subject to the exemption entitlement.

The employer and participant pay their respective premiums based on the pay the participant would receive if he were working and all provisions apply.

When the duration of the unpaid absence reaches the maximum provided for under the Act Respecting Labour Standards, the participant pays the two premiums (employee and employer share).

1.12.8 Non-rehiring, suspension and dismissal contested by appeal

The participant must maintain his participation under the Compulsory Basic Accident and Health Insurance Plan and pay all premiums (employee and employer share). He may, if he wishes, maintain his participation in the Compulsory Basic and Optional Life Insurance plans by assuming payment of the total premiums (employee and employer share). The request to maintain participation under the Compulsory Basic and Optional Life Insurance plans must be submitted to **SSQ within 90 days** following the event. Participation in the Compulsory Long Term Disability Insurance plans (Basic and CAP) is suspended during the contestation.

Regarding the Compulsory Long Term Disability Insurance plans, if the appeal favours the participant and if he is actually reinstated, premiums for these plans are payable by the employer retroactive to the date of non-rehiring, suspension or dismissal contested by appeal, and any disability that began since this date is then recognized.

1.12.9 Request to maintain coverage

A participant who wishes to maintain coverage must submit a request to his employer **before the beginning of one of the above-mentioned absence**. In the case of non-rehiring, suspension or dismissal, refer to *Section 1.12.8*.

When maintaining coverage, it is compulsory to participate in ALL the plans, including the survivor's pension for which the participant must assume the cost.

In the case of absences provided for in sections V.0.1 and V.1 of the Act Respecting Labour Standards, see clause 1.12.7.

However, a participant who does not have a spouse or dependent children and who provides evidence that no benefits will be payable under the survivor's pension may be exempted from participation in this plan during temporary absences from work as described in this section, according to the conditions determined in the working conditions. The participant must complete the form entitled *Request for exemption of participation in the survivor's pension plan* available from their employer.

In the case where a participant **terminates** his participation, this decision is **irrevocable**.

1.13 SABBATICAL LEAVE WITH DEFERRED EARNINGS

Coverage and premiums for all the insurance plans in which the participant participates are maintained, both during the periods of accumulated leave and the period of leave itself, based on the earnings he would have had received had he not participated in the deferred income plan.

Any disability that begins during the period of leave is deemed to have begun on the planned date of return to work.

1.14 MEASURES FOR END OF AGREEMENT, EMPLOYMENT OR CONTRACT, REDUCTION OF SURPLUS OR LEAVE OF ABSENCE, EARLY RETIREMENT (TOTAL OR GRADUAL) OR PROGRESSIVE RETIREMENT

Specific rules for eligibility and participation in insurance plans are applicable at the time of the above-mentioned situations and terminate upon retirement or breach of employment relations.

The participant must contact his employer's personnel department for full details of such a situation.

The general rules for eligibility and participation in insurance plans during these events are described below.

Participation in the Compulsory Basic Accident and Health Insurance Plan is maintained. The participant is responsible for paying his portion of the premiums, and the employer continues to pay its portion. The participant also maintains participation in the Compulsory Basic and Optional Life Insurance plans, as well as in the survivor's pension and all related premiums (employee and employer share) continue to be paid based on the earnings received. In the case of early retirement, premiums and coverage are established based on the earnings received prior to the agreement.

Participation in the Compulsory Long Term Disability Insurance Plans (Basic and CAP) ceases on the start date of the event, except in the event of gradual early retirement or progressive retirement over more than 104 weeks. In these two situations, participation in the Compulsory Long Term Disability Insurance Plans (Basic and CAP) ceases at the 104th week preceding the definitive date of retirement. Premiums and coverage are established based on earnings received.

If the participant wishes to use the earnings received immediately before the event for calculation purposes, he can make a request as explained under *Section 1.12.8*. **He must then assume full payment of all premiums (employee and employer share) for the insured plans and for the survivor's pension. These premiums are established on the portion of earnings not received.**

1.15 TERMINATION OF INSURANCE

The insurance for any participant terminates on the first of the following dates:

- the date on which he ceases to be part of the management personnel of the Quebec public and parapublic sectors, except for a participant maintaining participation in accordance with his working conditions; in this case, it is the date he loses his status as an employee;
- the date of retirement;
- the date on which the plan terminates;
- the date premium payments cease;
- at the end of the period of the employer's short-term disability benefit (104 weeks), if the participant becomes totally disabled after age 63;
- upon termination of Long Term Disability Insurance benefits, except if the termination is due to a total early retirement.

In addition to the preceding, premiums cease to be payable (and consequently coverage ceases) for the Compulsory Long Term Disability Insurance plans (Basic and Additional) at age 63.

Insurance for a spouse, dependent children or a person suffering from a functional impairment terminates on the first of the following dates:

- the date upon which the participant's insurance terminates;
- the date on which the insured ceases to be a spouse, dependent child or a person suffering from a functional impairment;
- the date upon which the participant's employer receives a request from the participant for Single-Parent or Individual coverage status, as the case may be;
- 6 months after the participant's death (*see Section 1.16.4 hereafter*).

1.16 EXTENSION AND CONVERSION PRIVILEGE

While the contract is in force, when a participant ceases to be eligible for insurance because he leaves his employment or retires, his Life Insurance coverage (Basic and Optional) is extended for a period of 31 days.

1.16.1 Participant's Compulsory Basic Life Insurance

During this 31-day period, the participant may apply to SSQ for an individual life insurance contract, without evidence of insurability being required, the amount of this insurance not exceeding one (1) time his annual earnings if he has no dependent children, or two (2) times his annual earnings if he has a spouse or dependent children. For participants eligible for the plan for retired management personnel or another group insurance plan, this amount is reduced by the maximum amount of life insurance available under that plan. Only the surplus may be converted up to a maximum of \$500,000.

1.16.2 Participant's Optional Life Insurance

If the participant has Optional Life Insurance coverage, the amount of insurance may be converted into an individual life insurance contract for an amount of coverage equivalent to that in force before the termination of his insurance.

To do so, the participant must send a written request to SSQ within the 31-day extension period.

The following table shows the amounts that can be obtained in accordance with the conversion privilege:

| Conversion privilege (in units of earnings) | | |
|--|---|--|
| Amount of Life Insurance | Conversion Privilege ⁽¹⁾ | |
| | With no spouse or dependent children | With spouse or dependent children |
| Basic (½ time) | 1 time | 2 times |
| Basic + Opt. (1 time) | 2 times | 3 times |
| Basic + Opt. (2 times) | 3 times | 4 times |
| Basic + Opt. (3 times) | 4 times | 5 times |
| Basic + Opt. (4 times) | 5 times | 5 times |
| Basic + Opt. (5 times) | 5 times | 5 times |

⁽¹⁾ This amount is reduced by the maximum amount of life insurance available under another group insurance plan (including the plan for retired management personnel for which the available amount is 1.5 times the earnings) for which the participant became eligible when he exercised his conversion privilege. Only the surplus can be converted up to a maximum amount of \$500,000.

1.16.3 Spouse's and Dependent Children's Life Insurance

The amount of life insurance provided for the spouse and dependent children under the Compulsory Basic Life Insurance Plan and the amount of Spouse's Optional Life Insurance can be converted to individual life insurance without evidence of insurability being required in the event the participant ceases to be eligible for the plan.

However, the amount of life insurance that can be converted is reduced by the amount of life insurance available for these dependents under another group insurance plan to which the participant would have become eligible when the dependent involved exercised the conversion privilege.

This privilege preserves the insurability of the spouse and dependent children, provided the insured submits his request for conversion to SSQ within 31 days following termination of his participation.

1.16.4 Upon the death of a participant who held Family or Single-Parent coverage status

The participant's spouse, dependent children and persons suffering from a functional impairment **continue to be covered under the benefits provided** under the Compulsory Basic Accident and Health Insurance Plan and the Spouse's and Dependent Children's Life Insurance Plan without payment of premiums **for a maximum period of 6 months** beginning on the date of participant's death.

After this 6-month period, the spouse and dependent children may take advantage of the conversion privilege, provided in *Section 1.16.3* to obtain life insurance coverage.

The Basic Accident and Health Insurance Plan can be maintained, with the exception of prescription drugs, in a separate plan offered by SSQ without evidence of insurability and for which the premium is payable directly to SSQ in accordance with the conditions in force at the time of the request. This request for the accident and health insurance plan must be submitted to SSQ within 31 days following the termination of the 6-month period mentioned above. After this period, no coverage is available.

The conversion privilege for the Basic Accident and Health Insurance Plan is available only when the person is not eligible for coverage under another group insurance plan.

1.17 PREPAYMENT ENTITLEMENT - LIFE INSURANCE PLANS (COMPULSORY BASIC AND OPTIONAL)

When a participant's coverage is extended without payment of premiums in accordance with the provisions in the "Waiver of premiums" clause and his life expectancy is no more than 12 months, he is entitled, provided he submits a written request to SSQ, to receive a disability benefit equal to 25% of the amount of life insurance for which he is covered. The amount of life insurance is determined by immediately considering any reduction in coverage provided for in the contract that is due to occur during the 24-month period following the date of the participant's request.

The participant who wishes to exercise this privilege must provide SSQ with evidence showing:

- a) that his life expectancy is less than 12 months at the date of his request; and, if applicable,
- b) the consent of his designated irrevocable or revocable beneficiary if the latter is other than "the participant's estate or assignees."

The insurance amount payable upon the death of the participant is reduced by the prepayment to which is added the interest based on the average rate of return of one-year treasury bills, plus 2%. Interest runs from the prepayment date until the final payment of the outstanding balance on the insurance amount payable upon the participant's death.

1.18 PROVISIONS IN FORCE DURING DISABILITY

Whenever a participant becomes disabled, the provisions applicable for the Compulsory Basic Life Insurance and Basic and Additional (CAP) Long Term Disability Insurance Plans are those of the contract in force on the date of onset of disability.

Any changes to these plans while the participant is disabled apply when the participant qualifies for a new period of disability under the short term disability plan offered by the employer.

Any changes to the Compulsory Basic Accident and Health Insurance Plan apply as of their effective date, whether or not the participant is disabled on this date.

1.19 CURRENCY

All amounts mentioned in this booklet are in Canadian currency.

2- COMPULSORY BASIC ACCIDENT AND HEALTH INSURANCE PLAN

2.1 HOSPITAL EXPENSES (reimbursed at 100%)

2.1.1 Hospital expenses in Quebec

Subject to Quebec's Hospital Insurance Act, when a participant incurs hospital expenses in Quebec for himself or one of his insured dependents as a result of accident, illness, pregnancy or serious complications arising from pregnancy, he is entitled to a reimbursement of such expenses up to **100% of the cost of a semi-private room, and up to the highest rate.**

The patient contribution required for accommodation or long-term care by a health facility and administrative fees required by the hospital are not covered by this clause.

2.1.2 Medical and hospital expenses outside Quebec

When medical and hospitalization expenses are incurred for treatment that cannot be provided in Quebec, expenses in excess of those paid by the Régie de l'assurance maladie du Québec (RAMQ) are eligible insofar as they have been pre-authorized by the RAMQ and are in compliance with Quebec's Hospital Insurance Act standards, subject to the following maximum amounts:

- medical expenses:
three (3) times the amount paid for professional fees by the RAMQ;
- hospital expenses:
one (1) time the amount paid for hospitalization expenses by the RAMQ.

2.1.3 Transportation and accommodation expenses for care not available in Quebec

Eligible expenses include the cost of any transportation and accommodation for care pre-authorized by the Régie de l'assurance maladie du Québec (RAMQ) but not available in Quebec. Such expenses are reimbursed to a maximum of \$5,000 per insured, per calendar year.

This coverage complements coverage for medical and hospitalization expenses for care not available in Quebec.

2.2 PRESCRIPTION DRUGS AND PARAMEDICAL EXPENSES (reimbursed at 75% or 100%, as applicable)

Subject to Quebec's Health Insurance Act, when a participant incurs, for himself or for an insured dependent, expenses resulting from accident, illness, pregnancy or serious complications arising from pregnancy, expenses eligible under this section are reimbursed at 75% for the first \$3,000 of eligible expenses and at 100% for any surplus, per certificate and per calendar year (excluding hospital expenses, travel insurance and trip cancellation insurance). The term 'certificate' refers to Individual, Single-Parent or Family coverage status.

These expenses are also eligible for non-emergency care outside Quebec. However, under such circumstances, these expenses are reimbursed up to what would have been reimbursed by SSQ had they been incurred in Quebec.

Definition of eligible expenses and reimbursement

When the term “eligible expenses” is used in the description of a benefit, the amount of eligible expenses must be multiplied by the percentage of reimbursement to establish the maximum amount of reimbursement.

The maximum reimbursement per calendar year corresponds to the total of all reimbursements made by SSQ for expenses incurred between January 1 and December 31 of the same year.

E.g.: Physiotherapy treatment expenses

- a) Example 1: Receipt submitted: \$80
This amount is adjusted to the \$40 maximum and reimbursed at 75%, namely \$30.
- b) Example 2: Receipt submitted: \$40
This amount is reimbursed at 75 %, namely \$30.

Eligible expenses detailed in *Sections 2.2.2 to 2.2.15 inclusive and Sections 2.2.32 and 2.2.33* must be prescribed by a physician.

To be eligible, expenses incurred for services or treatments provided by a health professional must be for fees payable to a person who is a member in good standing of the professional corporation relevant to the services or treatments involved, or if such a corporation does not exist, to a related professional association recognized by SSQ.

Services or supplies, examinations, care or expenses must comply with the customary and reasonable standards of current practices of the health professionals concerned.

Eligible expenses are limited to one (1) treatment or consultation per day per specialty (unless otherwise specified) per insured and include, provided they are necessary for the medical treatment of the participant or insured dependents:

- 2.2.1 Expenses for eligible pharmaceutical services and for drugs that can only be obtained by prescription or sold under pharmaceutical control,** bearing a valid DIN (Drug Identification Number) issued by the Federal government, prescribed by a health professional authorized by law to do so, available only in pharmacies and sold by a pharmacist or a health professional in accordance with section 37 of the Pharmacy Act, upon submission of suitably itemized and duly paid receipts.

The drugs referred to in this clause are those for which the use is in compliance with government-approved indications or, in the absence of such, indications provided by the manufacturer. However, some of these drugs, commonly called “RAMQ exception drugs”, are covered only if they meet the conditions and therapeutic indications determined by the regulations applying to the Basic Prescription Drug Insurance Plan.

An exception drug requires prior authorization from SSQ in order to be covered.

In the case of medication injected by a health professional in a private practice, only the injected substance is covered, and not the medical procedure, up to a maximum reimbursement of \$20.

Smoking cessation products covered under the Basic Prescription Drug Insurance Plan are also covered under this plan, and subject to a maximum reimbursement equal to the amount established and updated each year by the Régie de l'assurance maladie du Québec.

For insureds age 65 or over, this clause covers the patient contribution (deductible and coinsurance) required for an insured covered under the Public Prescription Drug Insurance Plan administered by the RAMQ.

Intra-uterine devices (I.U.D.) prescribed by a physician are also covered under this benefit.

Mandatory generic substitution

If the insured chooses to purchase an eligible brand name drug instead of any existing generic equivalent, the amount of reimbursement will be determined in accordance with its lowest cost generic equivalent. However, it is possible to obtain a reimbursement based on the cost of the brand name drug that cannot be substituted for medical reasons by submitting the appropriate form, duly completed by the attending physician, and provided the request is approved by SSQ.

A “brand name drug” is a patented drug for which there is at least one generic equivalent.

A “generic drug” is a copy of an original version of a drug for which the patent is expired and which contains the same active ingredients as the brand name drug.

Transfer of all contributions spent on prescription drugs, combined

A participant who changes insurance plans during the course of the calendar year can obtain, for himself and his dependents, a year-to-date statement of contributions. This statement is issued by the insurer or by the RAMQ, upon request by the participant or the employer, for each person affected by the change in insurance. In all cases, requests for statements must be made within six months of the termination of the insurance. This means that the participant is not forced to pay out-of-pocket for drugs under the new plan when the plan's annual limit is reached.

Note: If the participant remains with SSQ, the year-to-date contribution is automatically transferred.

Direct reimbursement service for prescription drug purchases

The plan includes the direct reimbursement service at the pharmacy for the purchase of medication. This way, the insured only pays the part of the cost of the medication that is not reimbursed by the insurance plan since SSQ reimburses the insured portion directly to the pharmacist.

For example, for \$40 in eligible medication expenses, reimbursable at a rate of 75%, the insured only pays \$10 to the pharmacist.

The procedure to use this service is described in *Section 8. How to submit a claim.*

Exclusions to prescription drug coverage:

This clause does not cover the following products, whether or not they are considered drugs:

1. dietary supplements intended as a meal supplement or replacement;
2. experimental drugs or those obtained under the federal Emergency Drug Release Program;
3. products or drugs used for infertility treatment, artificial insemination or in vitro fertilization, except those covered under a provincial prescription drug insurance plan;
4. products used for aesthetic, cosmetic or personal hygiene purposes;
5. smoking cessation products, except those specifically covered under the Basic Prescription Drug Insurance Plan;
6. curative or preventive vaccines, serums and injections, however, certain expenses are covered under paragraphs 2.2.16 and 2.2.20 of this section;
7. drugs used to treat erectile dysfunction;
8. sunscreens;

However, dietary supplements prescribed as treatment for a clearly diagnosed metabolic disease, in accordance with the conditions and directions for use determined by the regulations applicable to the Basic Prescription Drug Insurance Plan, remain covered.

This clause must not exclude supplies and therapeutic services covered under the Basic Prescription Drug Insurance Plan.

2.2.2 Expenses incurred for home care. In this clause:

- **“basic daily activities”**: means eating, dressing, moving around or satisfying basic hygienic requirements;
- **“home assistance service supplier”**: means a person working for remuneration for an incorporated or registered agency or cooperative specializing in home care, as well as any self-employed worker contracted by such cooperative or agency, as well as any self-employed worker, only if there is no agency or cooperative in the region
- **“family member of the participant or spouse”**: means spouse, son, daughter, father, mother, brother, sister, father-in-law, mother-in-law, brother-in-law, sister-in-law, half-brother, half-sister, son-in-law, daughter-in-law, grandparents and grandchildren.

Eligible expenses are those incurred by the insured during a period of convalescence rendered necessary following hospitalization or day surgery and during which he is unable to carry out his basic daily activities.

- a) **nursing care:** fees of a registered nurse or nursing assistant for nursing care rendered at the insured's residence up to an eligible expense of \$60 per day. The nurse must not ordinarily reside in the insured's home nor be a member of the participant's or spouse's family. The nursing care covered includes, among others:
- re-education following surgery;
 - checking blood pressure and vital signs;
 - changing bandages and dressing wounds;
 - administering medications and monitoring solutions;
 - removal of sutures and staples;
 - taking samples (e.g. blood, etc.).
- b) **transportation expenses:** expenses for transportation of the insured to receive medical care or medical check-ups following hospitalization or day surgery, up to a maximum of three (3) round trips per week and a maximum eligible expense of \$30 per round trip.
- c) **convalescent home:** expenses incurred for a stay at a convalescent home supervised by a physician or a registered nurse, including the cost of accommodation, meals and nursing care up to a maximum eligible expense of \$125 per day.
- d) **home assistance services:** fees of a home assistance service supplier to help the insured carry out his basic daily activities up to an eligible expense of \$60 per day. These services must be rendered at the insured's home and the supplier of the home care services must not ordinarily reside in the insured's home nor be a member of the participant's or spouse's family. The services covered include, among others:
- personal care (assistance with bathing, dressing/undressing, general hygiene, help or assistance with eating, help getting in and out of bed, etc);
 - household maintenance (regular maintenance, dish-washing, laundry);
 - general home maintenance (snow removal, lawn mowing, etc);
 - meal preparation;
 - accompaniment to medical appointments;
- e) **childcare expenses:** the expenses for taking care of the participant's dependent children at his home or at a day care centre, up to an eligible maximum of \$25 per day per child. The person providing these services must not ordinarily reside in the insured's home nor be a member of the participant's or spouse's family.

Only expenses that exceed those normally incurred by the participant or his spouse prior to the period of convalescence are covered under this clause.

Limitations regarding home care

Only expenses incurred for care received **within 30 days** immediately following hospitalization or day surgery are covered under this clause. Hospitalization following childbirth is not covered unless complications require hospitalization for an extended period of four (4) days or more.

Recommendations

- We invite the participant to check with the local CLSC, CISSS or CIUSSS to learn about the services available and provided for its health condition, as well as to ensure that its file is adequately monitored by the CLSC, CISSS or CIUSSS.
- Although the participant is not required to obtain prior authorization from SSQ, the participant may wish to contact SSQ Customer Service to assess its file and avoid any unpleasant surprises in the event that the treatment required by its health condition is not covered under the insurance contract.

2.2.3 Expenses for the rental or purchase, whichever is more economical, of a **non-motorized wheelchair** or a **hospital bed** for temporary use;

2.2.4 Expenses for the purchase or replacement of **artificial limbs** or **external prostheses** except for eyeglasses, contact lens or dentures.

The following expenses are covered:

- Expenses for the purchase of a **wig** required following chemotherapy. The maximum reimbursement per period of 48 full consecutive months is limited to one (1) wig per insured and a maximum of \$500 per insured;
- Expenses for the purchase of **intraocular lenses**, if required to correct the symptoms of an eye disease in cases where contact lenses or eyeglasses cannot be used to correct such symptoms;
- Expenses for the purchase of **breast prostheses** following a mastectomy;
- Expenses for the purchase of **surgical brassieres** following a mastectomy or breast reduction;

2.2.5 Expenses for the purchase, rental or replacement of **trusses, bandages, corsets, casts, splints, crutches** and **other orthoses**, it being understood that the expression “orthoses” describes certain parts assembled into a unit to support or maintain part of the body to prevent and correct physical deformities or to treat skeletal, muscular, or tendon disorders.

Expenses for the purchase of **orthotic shoe inserts** are also eligible. These are limited to the amounts provided in the price schedule of the *Association des orthésistes et des prothésistes du Québec*. The orthotic shoe inserts must be supplied by a specialized laboratory holding a permit issued by the Ministère de la Santé et des Services sociaux du Québec (MSSS) under the provisions of the Public Health Protection Act;

2.2.6 Expenses for the purchase of one (1) **device to measure blood glucose levels** (blood glucose monitor), up to an eligible expense of \$300 per 36-month period. Purchase of an intermittent blood glucose monitor requiring glucose sensors may also be eligible, provided prior approval by SSQ is obtained;

2.2.7 Expenses for the rental, adjustment, replacement or purchase, if the latter is more economical, of **therapeutic devices**.

Some examples of this category of devices include:

- aerosoltherapy appliances, namely devices required for treating, among others, acute emphysema, chronic bronchitis or chronic asthma (e.g.: vaporizer);
- non-union bone stimulators;
- respiratory monitors in case of respiratory arrhythmia (e.g.: apnea monitor);
- intermittent positive pressure respirators (e.g.: volume ventilator, CPAP);
- burn treatment garments (e.g.: Jobst);
- purchase of diapers for incontinence, probes, catheters and other similar sanitary articles required following a total and irrecoverable loss of bowel or bladder functions, the expression "loss" includes loss of use.

Exclusions applying to therapeutic devices

This benefit does not cover monitoring equipment (such as stethoscopes, reflectometers or other similar devices) or home accessories.

"Home accessories": means toilet seats, support rails, humidifiers, air conditioners, "air filters", Doctor Gibaud articles (heating devices), heating pads, heated car seat cushions, sun lamps, thermometers, sitz baths, pressure devices, sphygmomanometers or similar devices, electric toothbrushes ("Waterpik"), hydrotherapy devices, whirlpool bath, sheepskin (for bedsores), alarms for children suffering enuresis (nighttime incontinence) and other accessories of this type;

2.2.8 Costs covered for one (1) **insulin pump** are the purchase of the pump and its repair up to \$7,500 per 60-month period per insured and the purchase of items needed to operate the pump up to \$4,000 per calendar year, per insured;

2.2.9 Purchase, rental, adjustment, replacement or repair expenses for **percuteaneous or transcutaneous electrical nerve stimulator** (PENS/TENS) up to an eligible expense of \$1,000 per period of 60 months per insured;

2.2.10 Expenses incurred for the purchase of **orthopaedic shoes**, namely made-to-measure shoes designed and made for an insured from a cast, or prefabricated open, flared, straight shoes as well as those needed to support Dennis Browne splints when such shoes are required to correct or compensate for a foot defect and when they are obtained from a **specialized orthopaedic laboratory** holding a permit issued by the ministère de la Santé et des Services sociaux du Québec (MSSS).

Also eligible are expenses incurred for corrections made by such a laboratory to prefabricated shoes. Deep shoes as well as all types of sandals are not eligible;

- 2.2.11** Expenses incurred for **electrocardiograms, X-rays (including scanner), magnetic resonance, ultrasounds and lab tests**, performed outside of health institutions. Laboratory tests covered are the same as those available at a hospital and must be recognized by Health Canada;
- 2.2.12** Expenses incurred for the rental or purchase, if the latter is more economical, of a **respirator and oxygen** (e.g.: concentrator, oxylyte).
The cost to purchase an oxygen filling station may be eligible for reimbursement if the participant can demonstrate that it is cheaper for the plan to purchase than to have the tank filled;
- 2.2.13** Expenses incurred for the **professional fees of a registered nurse or registered nursing assistant** that are provided **exclusively for the patient** for a period of 8 hours or more per day, provided such services are rendered during a convalescence period outside a health institution or convalescent home. The person providing these services must not ordinarily reside in the participant's home nor be a member of the participant's or spouse's family;
- 2.2.14** Expenses for **cosmetic surgery** necessary to repair a disfigurement due to an accident that occurred while the insurance was in force;
- 2.2.15** Expenses for the purchase of **medium or full support compression stockings** (21 mm Hg or more), supplied and sold in a pharmacy or a medical establishment, in cases of venous or lymphatic system deficiency, subject to a maximum reimbursement of three (3) pairs per insured, per calendar year;
- 2.2.16** Expenses for **sclerosing injections**, up to an eligible expense of \$20 per treatment for the substance and \$25 per treatment for the medical procedure, maximum one (1) treatment per day;
- 2.2.17** Expenses incurred to rent, purchase or repair a **hearing aid**, up to \$1,000 per period of 48 full consecutive months per insured;
- 2.2.18** Professional fees of a **dental surgeon for treatment of a fractured jaw or injury to natural teeth**, further to an accident while the insurance was in force, provided such treatment is rendered within 12 months following the date of the accident.
Eligible expenses are limited to the rates provided in the current edition of the Quebec Dental Surgeons Association's fee guide.
However, no benefits are payable for any act, treatment, or prosthesis of any nature related to a dental implant;
- 2.2.19** Expenses for **round-trip transportation by ambulance**, including transportation by a regular scheduled airline (excluding air ambulance) in an emergency situation.
Medical necessity must be demonstrated when a claim for transportation by air is submitted to SSQ.
- 2.2.20** Expenses incurred for the substance used in **preventive or curative vaccines**, up to an overall eligible amount of \$200 per insured, per calendar year;

- 2.2.21 Expenses for **eye examinations** by an ophthalmologist or an optometrist, subject to a maximum of \$50 per insured per period of 24 full consecutive months;
- 2.2.22 Expenses for the services of a **physiotherapist, physical rehabilitation therapist or certified athletic therapist**, subject to a maximum eligible expense of \$40 per treatment;
- 2.2.23 Professional fees of a **speech-language pathologist**, up to \$60 per consultation, subject to a maximum reimbursement of \$600 per insured per calendar year;
- 2.2.24 Professional fees of an **occupational therapist**, up to \$40 per consultation, subject to a maximum reimbursement of \$500 per insured per calendar year;
- 2.2.25 Professional fees of an **audiologist or hearing aid specialist**, up to \$60 per consultation for an **audiologist** and up to \$40 per consultation for a **hearing aid specialist**, subject to a combined maximum reimbursement of \$500 per insured per calendar year;
- 2.2.26 Professional fees of a **chiropractor**, up to \$30 per treatment and \$50 per calendar year for X-rays, and subject to a combined annual reimbursement of \$500 per insured;
- 2.2.27 Professional fees of a **dietitian**, up to \$30 per consultation, subject to a maximum reimbursement of \$500 per insured per calendar year;
- 2.2.28 Professional fees of a **podiatrist**, up to \$40 per consultation, subject to a maximum reimbursement of \$500 per insured per calendar year;
- 2.2.29 Professional fees of a **naturopath (or naturotherapist), homeopath or phytotherapist**, up to \$30 per treatment or consultation, subject to a combined maximum reimbursement of \$600 per insured per calendar year.

The notion of “treatment” does not refer to any remedies, products or other articles such professionals may provide.

As regards the naturopath (or naturotherapist), eligible expenses are those related to a consultation in order to obtain dietary advice or for a check-up or to develop a diet based on natural products. Natural products, massages, baths, posturology, physical exercises or other consultations not recognized by SSQ are not covered.

- 2.2.30 Professional fees of an **acupuncturist, osteopath, kinesi therapist, ortho therapist or massage therapist**, up to \$30 per treatment or consultation, subject to a combined maximum reimbursement of \$600 per insured per calendar year;
- 2.2.31 Professional fees of a **psychiatrist, a psychoanalyst, a psychologist, a psychotherapist, a social worker, a guidance counsellor or a marital and family therapist**. Eligible expenses are subject to a combined overall maximum reimbursement of \$1,000 per insured, per calendar year;

2.2.32 Transportation and accommodation expenses (including meals) incurred in Quebec due to one of the following events:

- consultation **with a medical specialist for professional services not available** within a 200 km radius of the insured's place of residence;
- specialized **treatments provided by a physician and not available** within a 200 km radius of the insured's place of residence;
- hospitalization **for treatment not available** within a 200 km radius of the insured's place of residence;

Eligible expenses are:

- Expenses for **transportation** by automobile or with a public carrier by bus, train, boat or air, whichever is the most economical means, taking into account the health condition of the insured.
- Expenses for **meals**;
- Expenses **for accommodation** incurred for a stay in a commercial establishment, provided that the event requires an overnight stay.

The combined maximum reimbursement is \$1,000 per insured per calendar year.

However, the following conditions apply to the eligible expenses indicated above:

- the event incurring these eligible expenses must be on a physician's orders;
- receipts or paid invoices are required for the reimbursement of eligible expenses;
- the event incurring these eligible expenses must require travel of at least 200 km one way by the most direct route, from the insured's place of residence to the place of the event. In addition, the event must take place at the closest possible site to the insured's place of residence;
- reimbursement of eligible expenses for accommodation and meals is subject to production of receipts or paid invoices and is limited to the amounts detailed in the *Directive sur les frais remboursables lors d'un déplacement et autres frais inhérents*, applicable to management personnel of the Quebec public and parapublic sectors;
- eligible expenses for trips by automobile are equal to those that would have been incurred had the trip been taken by bus;
- eligible expenses include expenses incurred by the insured as well as the person accompanying the insured.

Comment:

These expenses may be eligible for reimbursement under a program administered by the establishment responsible for the insured's treatment. In order to verify whether such a program exists in their region of residence, insureds should contact their local hospital, CLSC, CISSS or CIUSSS. These organizations are "first payers" and only expenses that are not reimbursed by these organizations and that are eligible under the contract will be reimbursed.

2.2.33 In the case of **detoxification treatment** for alcoholism, cyberaddiction or drug or gambling addiction, the expenses incurred for a stay in a centre **officially recognized** for such purposes are eligible, up to an eligible expense of \$50 per day and 30 days per insured, per calendar year.

2.3 EXCLUSIONS

Under the prescription drug benefit, certain products are excluded from coverage. The participant is invited to read these exclusions carefully under *Section 2.2.1*.

Moreover, **no benefits are payable** for expenses incurred:

- as a result of an accident or illness for which the participant is entitled to compensation under the Act respecting industrial accidents and occupational diseases, the automobile insurance Act or any other similar legislation of another Canadian province or another country;
- for medical examinations for the purposes of a third party (insurance, school, employment, etc.);
- for trips for health reasons, except those expressly provided for;
- for eyeglasses or contact lenses;
- as a result of self-inflicted injury, regardless of the state of mind of the insured;
- for dental care or cosmetic surgery, except those expressly provided for;
- as a result of an accident suffered or illness contracted while the insured is on active duty in the armed forces;
- for care and services provided by a member of the participant's family;
- for medical services for which the insured is not required to pay, or for which he would not have been required to pay had he availed himself of any public plan for which he was eligible, or for which he would not have been required to pay in the absence of his group insurance plans, including expenses covered under a plan financed wholly or partly by taxes or under any government initiative and those which would have been covered had the provider of such services chosen to participate in such a plan;
- for all products, devices or services used or offered for experimental purposes or in the medical research stage, or whose use does not comply with the indications approved by the appropriate government authorities or, in the absence of such, with the indications provided by the manufacturer;
- for all substances, care or procedures relating to infertility treatment, artificial insemination or in vitro fertilization, except drugs covered under a provincial prescription drug insurance plan;
- for services or supplies, examinations, care or expenses that do not comply with the customary and reasonable standards of current practices of the health professionals concerned.

2.4 COORDINATION

If the total amount of benefits payable under this plan, and those payable under the terms of any other group or individual insurance plan under which the participant is entitled to receive benefits, exceeds the expenses actually incurred for the supplies and services covered under the contract, the benefits payable under this plan are reduced so as to eliminate this surplus.

3- DESCRIPTION OF THE TRAVEL INSURANCE AND TRIP CANCELLATION INSURANCE BENEFITS

3.1 DEFINITIONS APPLICABLE TO TRIP CANCELLATION INSURANCE

Under this benefit, the words and expressions below are defined as follows:

- **Accident**
An unintentional, sudden, unforeseen and unpredictable event due exclusively to a violent external cause and resulting, directly and independently of any other cause, in bodily injury;
- **Business partner**
A person with whom the insured is associated for business purposes in a company composed of four (4) co-shareholders or fewer, or a commercial company or association composed of four (4) partners or fewer;
- **Commercial activity**
An assembly, conference, convention, exhibition, trade fair or seminar of a professional or commercial nature. The activity must be public, under the responsibility of an official organization and in compliance with the legislation, regulations and policies of the region where it will be held. The activity must be the sole reason for the planned trip;
- **Family member**
Spouse, son, daughter, father, mother, brother, sister, father-in-law, mother-in-law, grandparents, grandchildren, half-brother, half-sister, brother-in-law, sister-in-law, son-in-law, daughter-in law;
- **Host at destination**
The person with whom the insured shares accommodation arranged in advance, provided the accommodation is at the principal residence of the host at destination;
- **Prepaid travel expenses**
Refers to the following:
 - Expenses incurred by the insured to purchase a trip, including tickets from a public carrier, rental of motor vehicles or accommodation from a business or booking platform which is accredited or authorized by the appropriate authorities to operate such a business or provide such services;
 - Amounts paid by the insured for travel arrangements usually included in a package trip;
 - Amounts paid by the insured in relation to registration fees for a commercial activity.
- **Travel companion**
The person with whom the insured shares accommodation at the travel destination, or whose transportation expenses were paid along with those of the insured;

- Trip

For Travel Assistance Insurance purposes: A trip taken outside the insured's usual province of residence. In this case, the term trip also applies to the insured's transportation between the departure and the return.

For Travel Cancellation Insurance purposes: An occasional trip made by an insured from the usual place of residence to temporarily visit another place. To be recognized as a trip under Travel Cancellation Insurance, the trip must also require a period of absence of at least 2 consecutive nights and must be for tourism, pleasure or attendance at a commercial activity. In addition, in the case of a cruise, it must be operated under the responsibility of an accredited firm.

3.2 TRAVEL INSURANCE (reimbursed at 100%)

Depending on the coverage status held (Individual, Single-Parent or Family), Travel Insurance covers the participant and, if they are insured, the spouse, dependent children, and persons suffering a functional impairment.

Expenses are eligible as long as they are incurred following a death, an accident or a **sudden and unexpected illness** occurring while the insured was temporarily outside his province of residence and requiring **emergency care**. The expenses must be incurred for supplies or services prescribed by a physician as necessary to treat an illness or injury.

If the insured already has a known disease or illness before a trip, he must ensure that his health condition is good and stable, that he can carry out usual daily activities and that he is experiencing no symptoms that may reasonably suggest that any complications may arise or that medical care may be required during the trip outside the province of residence. In other words, prior to departure, the known disease or illness must be under control and must not:

- have taken a turn for the worse;
- have relapsed or recurred;
- be unstable;
- be entering a terminal phase;
- be chronic and indicate a risk of deterioration or foreseeable complications during the trip.

If any of the aforementioned criteria is applicable to your current health condition, **the participant must contact** the travel assistance firm (CanAssistance) several weeks before the departure, to clarify whether the health condition of the insured meets the eligibility criteria for this coverage. CanAssistance's telephone numbers are printed on the back of the SSQ Card accompanying the certificate issued by SSQ.

Travel Insurance covers the insured provided that coverage is in force under the government health and hospitalization insurance plan of that person's province of residence (e.g.: the RAMQ). **For any trip scheduled for a period of time exceeding the period covered by these public plans, all excess days are not covered by this coverage.** Please refer to the public plan of your province of residence to learn about the applicable terms. If you plan to travel more than 180 days a year, you must contact SSQ in advance for information about applicable conditions.

3.2.1 Eligible expenses are as follows:

- the portion of **hospitalization** expenses in excess of the expenses covered under the provincial plan;
- the portion of professional fees of a **physician** in excess of expenses covered under the provincial plan;
- expenses for transportation by **ambulance** to the hospital that is nearest to the place the event occurred, by a licensed ambulance service;
- expenses for **drugs** requiring a medical prescription;
- professional fees of a **registered nurse** who is neither a relative nor a travelling companion of the insured, for private nursing care, provided exclusively in hospital, when medically necessary and prescribed by the attending physician. These expenses are limited to a maximum reimbursement of \$5,000;
- expenses for treatment by a **chiropractor, podiatrist or physiotherapist**;
- rental expenses for a **wheelchair, hospital bed or respirator**;
- **lab tests** and **x-ray** expenses;
- purchase cost of **trusses, corsets, crutches, splints, casts and other orthoses**;
- fees of a **dental surgeon** for accidental injuries to natural teeth, subject to a maximum reimbursement of \$1,000 per accident, for treatment provided within 12 months following such an accident;
- expenses to **return** the hospitalized insured to his province of residence, subject to prior authorization from SSQ*;
- the cost of **economy class return air travel** for a **medical escort**, subject to prior authorization from SSQ*;
- the cost of **returning**, by means of a commercial agency, **the insured's personal vehicle** or rental vehicle, to the insured's home or to the nearest appropriate vehicle rental agency, if the insured is incapable to do so personally due to an illness or injury or following the insured's death, up to a maximum reimbursement of \$2,000. A medical certificate attesting to the incapacity of the insured is required;
- in the event of the insured's death outside the insured's province of residence, the expenses for **preparing and returning the remains**, excluding the cost of the coffin or casket, by the most direct route to return to the province of residence, up to a maximum reimbursement of \$10,000; prior authorization from SSQ is required*;

- the cost of **accommodation and meals**, in a commercial establishment, that the insured must incur because the return is postponed following a hospitalization lasting at least 24 hours for one of the insureds, an immediate family member who is travelling with the insured or travel companion of the insured, up to \$300 per day and subject to a maximum of \$2,400 per trip for all insureds;
- the cost of **accommodation and meals**, in a commercial establishment, as well as return, economy-class **transportation expenses** by the most direct route by plane, bus or train, for only one close relative, either the spouse, the son or daughter, the father or mother or the brother or sister, in order to visit the hospital where the insured has been hospitalized for at least seven (7) days or to identify the body of the deceased insured; prior authorization from SSQ* is required and the insured must present a document provided by the attending physician or by the local authorities certifying that that visit was necessary. Eligible expenses are limited to the following:
 - for transportation: \$2,500;
 - for accommodation and meals: \$300 per day, up to a maximum of \$2,400 per trip for all insureds.

The notion of “close relative” may also include a friend in the event that the insured has no close relatives.
- travel assistance services as described below.

* The expression “**prior authorization from SSQ**” used in this text means SSQ or the travel assistance service (CanAssistance) which is authorized to act on behalf of SSQ (*see Section 3.3 hereafter*).

3.2.2 Reassignment outside of the province of residence

Hospital expenses and the professional fees of a physician in excess of those covered under the provincial plan, and which are not eligible as being due to non-urgent care or constituting fees related to a pregnancy, are covered under the present benefit when these fees are incurred while the participant is reassigned outside of his province of residence for work-related reasons for more than 30 consecutive days. To be eligible, these fees must be incurred in the area offering the care or services required that is closest to the place where the insured has been reassigned.

Note: Refer to *Section 3.5* for limitations and exclusions to this coverage.

3.3 TRAVEL ASSISTANCE

The Travel Insurance benefit includes a special travel assistance component. When needed, each insured has access to a travel assistance service when travelling outside of his province of residence. This service is offered by a specialized company (CanAssistance) under agreement with SSQ.

If emergency medical or hospital care or services provided under the Travel Insurance benefit become necessary, CanAssistance can not only advance the funds required, but also intervene to help arrange admission of the insured to hospital or arrange access to the various services provided under the insurance plan.

CanAssistance can act as the intermediary between SSQ and the insured when the latter must obtain “**prior authorization from SSQ**,” as stipulated under this Travel Insurance benefit, in order to be entitled to the services covered.

The following is a detailed list of the services CanAssistance can provide, if necessary, following an accident or sudden and unexpected illness:

- refer the insured to an appropriate clinic or hospital;
- verify the insured’s medical insurance coverage in order to prevent the insured from having to pay for services up front, where possible;
- ensure follow-up of the insured’s medical file;
- coordinate the insured’s return and transportation as soon as medically possible;
- provide emergency assistance and coordinate claims;
- arrange for the transportation of a family member to the bedside of the insured or to identify the insured’s body if deceased and coordinate the return of the deceased insured;
- arrange for the return of dependents to their home (return expenses not included);
- coordinate the return of the insured’s personal vehicle if he is unable to do so because of illness, accident or death;
- contact the insured’s family;
- act as an interpreter for emergency calls;
- recommend a lawyer in case of a serious accident (lawyer’s fee not included).

Insureds travelling outside of the United States or Western Europe may wish to contact CanAssistance prior to departure for useful health care advice.

CanAssistance representatives can be reached at the following numbers.

| | |
|---|----------------|
| A) CANADA - UNITED STATES | 1-800-465-2928 |
| B) ELSEWHERE IN THE WORLD (collect call) | 514-286-8412 |

The insured must provide the contract number specified on the participant’s SSQ Card when calling.

The above telephone numbers are also printed on the back of the participant’s SSQ Card. These numbers appear on the reverse side of the card.

Note: Refer to *Section 3.5* for limitations to this coverage.

3.4 TRIP CANCELLATION INSURANCE (reimbursed at 100%)

Trip Cancellation Insurance covers the participant and, if they are insured, his spouse, dependent children or persons suffering from a functional impairment, depending on the coverage status held (Individual, Single-Parent or Family).

Eligible expenses are those incurred by the insured following cancellation or interruption of a trip, provided these expenses relate to travel expenses paid in advance by the insured and provided that, at the time the expenses were made, he was unaware of any event that could have reasonably led to the cancellation or interruption of the planned trip.

3.4.1 Reasons for cancellation:

- a) an **illness** or **accident** suffered by the insured, his travel companion, a business associate or a member of his family (*see Section 3.1*), that prevents the insured from performing his usual activities and which is serious enough to justify cancellation or interruption of the insured's trip;
- b) the **death** of the participant, his spouse, a child of the participant or his spouse, a travel companion or a business associate;
- c) the **death** of a member of the insured's family (other than the participant, the participant's spouse or a child of the participant or the participant's spouse) or of the insured's travel companion, provided the funeral takes place during the period extending from 31 days before and 31 days after the planned trip;
- d) the **death** or emergency **hospitalization** of the host at destination;
- e) if the insured or his travel companion must **report for jury duty**, or receives a subpoena to appear as a **witness in a case** scheduled to be heard during the trip, but only if the person involved has taken all necessary measures to have the hearing postponed.

However, a subpoena is not considered cause for cancellation or interruption of a trip when the person involved institutes legal proceedings or is a defendant in the case or has been subpoenaed as part of his duties as a police officer;

- f) the **quarantine** of the insured, if such quarantine terminates seven (7) days or less before the scheduled date of departure, or occurs during the time of the trip;
- g) the **hijacking of the airplane** on which the insured is travelling;
- h) **damage** rendering the principal residence of the insured or of the host at destination uninhabitable, provided the residence remains uninhabitable seven (7) days or less before the scheduled date of departure or the damage occurs during the trip;

- i) the **transfer** of the insured, for the same employer, to a location more than 100 kilometres from his current residence, if required within 30 days preceding departure;

j) **For trip cancellation**

The issuance by the Government of Canada of an advisory:

- to avoid all travel, or to avoid non-essential travel, to a location where the insured plans to travel; or
- to avoid all cruise ship travel when the insured is scheduled to take a trip on a cruise ship.

The advisory must be issued after the insured has made the travel arrangements. The advisory must be in force on the scheduled date of departure.

For trip interruption

The issuance by the Government of Canada of an advisory:

- to avoid all travel, or to avoid non-essential travel, to a location where the insured is on a trip; or
- to avoid all cruise ship travel when the insured is already on a cruise ship.

The advisory must be in force during the trip. The insured must comply with the advisory within 14 days following its issuance.

- k) the **delay of the transportation** used by the insured to reach the point of departure of the planned trip or to the point of departure of a scheduled connection after departure of the planned trip. The means of transport used must provide for scheduled arrival at the point of departure at least 3 hours before the time of departure or at least 2 hours if the distance to be covered is less than 100 kilometres. The delay must be caused by weather conditions, mechanical problems (except for a private automobile), a traffic accident, or a road closure, each of the latter two causes requiring confirmation by a police report;

l) **weather conditions** such that:

- i) the departure of the public carrier, at the point of departure of the planned trip, is cancelled or is delayed for a period of at least 30% of the scheduled duration of the trip (minimum 48 hours); or
- ii) after departure, the insured is unable to make a scheduled connection with another carrier, provided the scheduled connection after departure is cancelled or is delayed for a period of at least 30% of the time scheduled for the trip (minimum 48 hours);

- m) **damage** to the place of business or physical location where a commercial business activity is to be held, such damage making it impossible to hold the planned activity, such that the official organization responsible for organizing the activity issues a written notice cancelling the activity;

- n) the **illness, accident or death** of a person for whom the insured is the legal guardian;
- o) the **suicide or attempted suicide** of a member of the insured's family or of the family of his travel companion;
- p) the **death** of a person for whom the insured is the testamentary executor;
- q) the **death or hospitalization** of the person with whom the arrangements for a business meeting or activities of a commercial nature had previously been made. **In such a case, the reimbursement is limited to transportation expenses and to a maximum of three (3) days of accommodation.**

3.4.2 Expenses covered under this benefit are payable at 100% up to a maximum of \$5,000 per insured for the planned trip, namely:

- a) In case of cancellation prior to departure
 - The non-refundable portion of prepaid travel expenses;
 - Additional expenses incurred by the insured in the event that the person who was to accompany him and share the room or the apartment at destination must cancel for one of the reasons mentioned under *Section 3.4.1* and the insured decides to proceed with the trip as initially planned, up to the amount of the cancellation penalty (single occupancy) applicable at the time the travel companion has to cancel;
 - The non-refundable portion of prepaid travel expenses, up to 70% of such expenses, if the insured's departure is delayed due to weather conditions and he **decides not to proceed with the trip.**
- b) In the event of missed departure, flight cancellation or if the trip must be interrupted temporarily

The additional cost of a one-way economy class ticket on a scheduled flight of a public carrier, by the most direct route to the initially-planned trip destination. Departure must be missed due to a cancelled flight or a delay in the means of transportation used by the insured, subject to the conditions specified in the eligible reasons for cancellation. In the event of interruption of a trip, the interruption must be due to an illness or accident suffered by the insured or travel companion, subject to the conditions specified under the eligible reasons for cancellation.

- c) If the return is earlier or later than scheduled
 - The additional cost of a **one-way economy class ticket**, by the most direct route, for a return trip to the point of departure, **by the means of transportation initially planned.**

If the means of transportation initially planned cannot be used, whether or not travel expenses have been prepaid, the expenses covered correspond to the expenses required by a scheduled carrier for an economy class ticket, by the most economical means, by the most direct route to return the insured to the point of departure.

These expenses require prior authorization from SSQ (see Section 3.3);

However, if the insured's return is delayed by more than seven (7) days as the result of an illness or accident suffered by the insured or his travel companion, the expenses incurred are covered provided the person in question is admitted to hospital as an inpatient for more than 48 hours within such seven (7)-day period.

If the travel expenses have not been prepaid, the expenses incurred by the insured are covered provided he was not aware, before the start date of the trip, of any event that could reasonably lead to the interruption of the planned trip;

- The unused and non-refundable portion of the **ground portion** of prepaid travel expenses.

Restriction:

Expenses payable by any person other than the insured are not covered.

d) Round-trip transportation

Trip Cancellation Insurance covers transportation expenses by the most economical means, after prior authorization from SSQ (see Section 3.3) to return the insured to his province of residence and then to return to the trip destination provided the reason is:

- the death or hospitalization of a family member of the insured, or a person for whom the insured is the legal guardian or testamentary executor;
- damage rendering the principal residence of the insured uninhabitable or causing major harm to his business establishment.

Note: Refer to *Section 3.5* for limitations and exclusions to this coverage.

3.5 EXCLUSIONS, LIMITATIONS AND COORDINATION

3.5.1 Exclusions applicable to Travel Insurance

This benefit does not cover:

- a. expenses incurred after the insured has returned to his province of residence;
- b. expenses payable under any social legislation or any insurance plan;
- c. expenses related to elective or non-emergency surgery or treatment, or if the trip is taken for the purposes of obtaining or with the intention of receiving medical treatment, a medical consultation or hospital services, whether or not the trip is taken upon the recommendation of a physician;
- d. hospital or medical expenses that are not insured in accordance with the provincial plan of the insured;
- e. expenses incurred abroad when such expenses could have been incurred in the province of residence of the insured without danger to his life or health, except for expenses required immediately following an emergency

- situation resulting from an accident or a sudden illness. The fact that the quality of the care provided in the province of residence is inferior to the care that can be provided outside the province does not constitute, within the meaning of this exclusion, a danger to the life or health of the insured;
- f. hospital expenses in a facility treating chronic illnesses or expenses for similar services in a public hospital, and expenses incurred in an extended-care or thermal spa facility;
 - g. expenses incurred in a location for which the Government of Canada issued an advisory to avoid all travel as well as expenses incurred during cruise ship travel while the Government of Canada issued an advisory to avoid all cruise ship travel. If the insured is already present at the location in question or on a cruise ship at the time the advisory is issued, they must comply with the advisory within 14 days following its issuance. If the insured does not comply with the advisory within 14 days following its issuance, no expenses incurred by the insured will be eligible after this deadline.

This benefit does not cover losses caused by the following or to which the following causes have contributed:

- h. active participation by the insured in a riot or insurrection, a criminal act or attempted crime;
- i. intentional self-inflicted injury by the insured or his travel companion, suicide or attempted suicide, regardless of the state of mind of the person. However, in the case of a death resulting from suicide, only the costs incurred to prepare and return the remains are covered under the provisions of this benefit;
- j. abusive consumption of medication, drugs or alcohol and the ensuing consequences;
- k. participation in extreme or combat sports, gliding, hang gliding, paragliding, bungee jumping, mountain climbing, parachuting or skydiving or any other similar activity, or participation in any motorized vehicle competition, or participation in any sporting activity involving remuneration;
- l. pregnancy, miscarriage, childbirth or related complications occurring within the two (2) months preceding the normal expected date of delivery;
- m. a trip taken for the purposes of obtaining or with the intention of receiving medical treatment, a medical consultation or hospital services, whether or not the trip is taken upon the recommendation of a physician.

3.5.2 Exclusions applicable to Trip Cancellation Insurance

- 1. These benefits do not cover losses caused by the following or to which the following causes have contributed:
 - a. active participation by the insured in a riot or insurrection, a criminal act or attempted crime;

- b. intentional self-inflicted injury by the insured or his travel companion, suicide or attempted suicide, regardless of the state of mind of the person. However, in the case of a death resulting from suicide, only the costs incurred to prepare and return the remains are covered under the provisions of this benefit;
 - c. abusive consumption of medication, drugs or alcohol and the ensuing consequences;
 - d. participation in extreme or combat sports, gliding, hang gliding, paragliding, bungee jumping, mountain climbing, parachuting or skydiving or any other similar activity, or participation in any motorized vehicle competition, or participation in any sporting activity involving remuneration;
 - e. pregnancy, miscarriage, childbirth or related complications occurring within the two (2) months preceding the normal expected date of delivery;
 - f. a trip taken for the purposes of obtaining or with the intention of receiving medical treatment, a medical consultation or hospital services, whether or not the trip is taken upon the recommendation of a physician.
2. No expenses are payable if the insured made travel arrangements while a Government of Canada advisory was in effect recommending:
- to avoid all travel to a location where the insured plans to travel; or
 - to avoid all cruise ship travel when the insured is scheduled to take a trip on a cruise ship;

However, this exclusion does not apply:

- to any trip cancellation for an eligible reason for cancellation other than the Government of Canada advisory if there is a change to the risk level of the advisory to a lower risk level before the scheduled date of departure; and
 - to any trip interruption for an eligible reason for interruption other than the Government of Canada advisory if there is a change to the risk level of the advisory to a lower risk level before the scheduled date of departure or during the insured's trip.
3. No trip interruption expenses are payable if the insured leaves on a trip while a Government of Canada advisory is in effect recommending:
- to avoid all travel to a location where the insured plans to travel; or
 - to avoid all cruise ship travel when the insured is scheduled to take a trip on a cruise ship;

However, this exclusion does not apply to any trip interruption for an eligible reason for interruption other than the Government of Canada advisory if there is a change to the risk level of the advisory to a lower risk level during the insured's trip.

4. No trip interruption expenses caused by the following advisory are payable if the insured leaves on a trip while a Government of Canada advisory is in effect recommending to avoid non-essential travel to a location where the insured plans to travel.

However, this exclusion does not apply to any trip interruption caused by the advisory if there is a change to the risk level of the advisory to a higher risk level during the insured's trip.

5. No trip interruption expenses caused by one of the following advisories are payable if, during the insured's trip, the Government of Canada issues an advisory:

- to avoid all travel or to avoid non-essential travel to a location where the insured already is and the insured does not comply with the advisory within 14 days following its issuance; or
- to avoid all cruise ship travel when the insured is already on a cruise ship and does not comply with the advisory within 14 days following its issuance.

If the insured does not comply with the advisory within 14 days following its issuance, no expenses incurred by the insured will be eligible after this deadline.

6. No trip interruption expenses for an eligible reason for interruption other than one of the following advisories are payable if, during the insured's trip, the Government of Canada issues an advisory:

- to avoid all travel to a location where the insured already is and the insured does not comply with the advisory within 14 days following its issuance; or
- to avoid all cruise ship travel when the insured is already on a cruise ship and does not comply with the advisory within 14 days following its issuance.

If the insured does not comply with the advisory within 14 days following its issuance, no expenses incurred by the insured will be eligible after this deadline.

3.5.3 Limitations to Travel Insurance

- In the event of a medical condition requiring extended medical services, treatment or surgery, if medical evidence indicates that after diagnosis or emergency treatment of this condition, the insured could have returned to his province of residence but chose to obtain services elsewhere, SSQ will not assume the cost of services, treatments, surgeries and other expenses.
- SSQ reserves the right to repatriate the insured to his province of residence when his medical condition permits. Any refusal to be repatriated discharges SSQ from any liability for expenses subsequently incurred.
- Total benefits may not exceed \$5,000,000 per insured, per trip abroad.

3.5.4 Limitations to Travel Assistance

- Neither SSQ nor the company providing travel assistance is responsible for the availability or quality of the medical and hospital care administered, or for the possibility of obtaining such care.
- Some of the services described may not be available in certain countries.
- The services offered are subject to change by SSQ without prior notice.

3.5.5 Limitations to Trip Cancellation Insurance

In the event of trip cancellation prior to departure due to a travel advisory issued by the Government of Canada, you must contact SSQ's travel assistance service for the procedure to follow either 72 hours before a deposit becomes due or 72 hours before the scheduled date of departure, whichever comes first.

In the event of trip cancellation prior to departure for any reason other than a travel advisory, you must contact SSQ's travel assistance service for the procedure to follow at the latest 48 hours following the event causing cancellation.

The telephone numbers to contact SSQ's travel assistance service are the following:

From Canada or the United States: 1 800 465-2928

From elsewhere in the world: (514) 286-8412 (collect call)

You must provide the contract number specified on your SSQ card when calling.

If notice of cancellation of a trip prior to departure is not provided within the time specified herein, SSQ's liability is limited to the cancellation expenses stipulated in the travel contract that are applicable at the time such notice should have been given. However, this limitation will not apply if the insured and any adult accompanying the insured on the planned trip provide proof deemed satisfactory by SSQ that they were totally incapable of doing so. In such case, the trip must be cancelled as soon as one of these persons is able to do so, and SSQ's liability is limited to the applicable cancellation fees stipulated in the travel contract at the time of cancellation.

3.5.6 Coordination

Expenses eligible for reimbursement under this contract will be reduced by the amount of any corresponding benefits payable under another individual or group insurance contract. However, if the insured is entitled to similar benefits under other provisions of this contract, benefits will only be payable under the provisions of this benefit. This clause should not be interpreted as limiting the scope of other coverage under the accident and health insurance plan when benefits are not payable under Travel or Trip Cancellation Insurance.

4- COMPULSORY BASIC LIFE INSURANCE PLAN

4.1 PARTICIPANT'S LIFE INSURANCE

The amount of coverage is equal to 50% of annual earnings.

4.2 SPOUSE'S AND DEPENDENT CHILDREN'S LIFE INSURANCE

- Spouse: \$17,200
- Dependent children
age 24 hours or over: \$5,000 per child

Note: These amounts are reduced by half for participants working less than 70% of full time.

4.3 PARTICIPANT'S, SPOUSE'S AND DEPENDENT CHILDREN'S ACCIDENTAL DISMEMBERMENT INSURANCE

As described in the following table, this benefit provides a payment not exceeding 100% of the participant's annual earnings if the participant, his spouse or dependent children suffer any of the following losses as a result of an accident within 365 days of such accident while insurance is in force;

| Loss | Amount |
|--|-------------------------|
| - both hands, both feet or complete loss of sight in both eyes | 100% of annual earnings |
| - one hand and one foot | 100% of annual earnings |
| - one hand and sight in one eye | 100% of annual earnings |
| - one foot and sight in one eye | 100% of annual earnings |
| - one hand | 50% of annual earnings |
| - one foot | 50% of annual earnings |
| - sight in one eye | 50% of annual earnings |

Note: "Loss" means total and irrecoverable loss of use of a limb as the result of an accident. Loss of sight means the total, definitive and irrecoverable loss of sight.

4.4 EXCLUSION IN THE EVENT OF ACCIDENTAL DISMEMBERMENT

Accidental Dismemberment Insurance is not payable if the loss is due to one of the following causes: self-inflicted injuries, suicide, war, riot, insurrection, active participation in a criminal act or attempted crime, active duty in the armed forces, carrying out any duties as an aircraft crew member (unless the participant is present as a crew member within the scope of his duties as a member of management personnel of the Quebec public and parapublic sectors).

5- OPTIONAL LIFE INSURANCE PLAN

The Optional Life Insurance Plan complements SSQ's Compulsory Basic Life Insurance Plan, the uniform life insurance plan and the survivor's pension plan.

5.1 PARTICIPANT'S OPTIONAL LIFE INSURANCE

The participant may add an amount equal to 1, 2, 3, 4 or 5 times his annual earnings.

Evidence of insurability

- a) Evidence of insurability is **always** required if the application for Optional Life Insurance is submitted **more than 60 days** after the eligibility date.
- b) Evidence of insurability is **always** required for any application for Optional Life Insurance greater than 3 times the participant's annual earnings, even if the request is submitted within the first 60 days of his eligibility.
- c) Evidence of insurability is also required for a new participant who submits his request within the first 60 days of his eligibility for an amount greater than \$167,800*, if he is age 40 to 49, and for an amount greater than \$69,900*, if he is age 50 or over.

* These amounts are those in force for 2021. They are adjusted on January 1 of each year, according to the pension Index for the Quebec Pension Plan, subject to a maximum of 4%.

5.2 SPOUSE'S OPTIONAL LIFE INSURANCE

To apply for Spouse's Optional Life Insurance, the participant must have Participant's Optional Life Insurance.

Coverage is available in increments of \$10,000, subject to a maximum of \$100,000; evidence of insurability are required at all times.

5.3 EXCLUSIONS

No benefits are payable for an insured (participant or spouse) in accordance with the present plan in case of suicide:

- if the amounts of coverage are requested more than 60 days after the eligibility date of the insured; and
- if the insured's death occurs within 12 months following the effective date of the additional amounts of coverage.

6- COMPULSORY BASIC LONG TERM DISABILITY INSURANCE PLAN

The Compulsory Basic Long Term Disability Insurance Plan is designed to complement the employer's short term disability insurance plan when a participant becomes totally disabled.

A brief description of this plan and the main conditions pertaining to it are presented hereafter:

6.1 AMOUNT OF PENSION

The monthly pension is equal to 65% of the gross monthly earnings the participant would have been entitled to, had he or she been at work at the end of the 104th week of total disability.

6.2 ELIMINATION PERIOD

The elimination period is 104 weeks, corresponding to the duration of the employer's short term disability insurance plan.

6.3 DURATION OF BENEFITS

A disabled participant is entitled to receive the Long Term Disability pension starting at the end of the elimination period for as long as he remains totally disabled, though not beyond the first of the dates mentioned under *Section 6.10 - Termination of benefits* hereafter.

6.4 COORDINATION OF BENEFITS

Monthly benefits are reduced by the amount of any monthly disability pension **paid** under the Act respecting industrial accidents and occupational diseases, the Quebec Automobile Insurance Act, the Quebec Pension Plan (QPP), under any previous contract and any other social legislation. This reduction also takes into account any applicable retroactive amounts.

If the participant is not receiving payments from the aforementioned sources of income, it is his responsibility to provide evidence that he is not entitled to any amount from such sources.

Moreover, the monthly pension is reduced by any amount of disability or retirement pension the participant receives under the employer's pension plan and the QPP.

This reduction is determined on the basis of the pensions payable after the 104th week of total disability, regardless of any future cost-of-living adjustments.

6.5 PENSION PLAN CONTRIBUTION

In addition to the disability pension, starting on the 156th week of total disability, SSQ pays the participant's contribution to the employer's pension plan if the participant was a contributor prior to his disability, for as long as the total disability persists, though not beyond the first of the dates mentioned under *Section 6.10 - Termination of benefits* hereafter.

In case of a terminal illness of an eligible participant in accordance with the provisions of the PPMP, RPSO, RREGOP or PPPOCS, if the participant requests reimbursement of his accumulated contributions with interest or the present value of his retirement pension, SSQ ceases the payment of the participant's contribution to the PPMP, RPSO, RREGOP or PPPOCS upon the date Retraite Québec receives the request for reimbursement.

6.6 DEFINITION OF TOTAL DISABILITY

Total disability is a state of incapacity resulting either from illness, accident, serious complication of pregnancy or surgery directly related to family planning requiring medical care and making the participant totally unable to carry out any remunerative employment for which he is reasonably qualified because of his education, training and experience, regardless of the availability of such employment.

6.7 PERIOD OF TOTAL DISABILITY (after 104 weeks)

Any continuous period of total disability or series of successive periods of total disability resulting from the same illness or accident, separated by a period of less than 3 months of active full-time work or, if applicable, part-time work, in accordance with the participant's regular position.

If, for a period, the total disability results from an illness or accident completely independent from the illness or accident that caused the total disability during the preceding period, such period is considered a new period of total disability.

6.8 INDEXATION

The amount of the pension payable by SSQ is indexed according to the lesser of the following percentages:

- a) the increase in the pay scale of civil servant managers (class 4) applied during the preceding year;
- b) 5%.

This indexation clause applies annually as of the January 1 that follows a period of at least six months of benefits.

If the participant ceases to receive payments from an income source used for the calculation of the coordination of the monthly benefit described in Section 6.4, the amount of the benefit payable under this plan is calculated again in order to include the benefit amount that was taken into account for the calculation of the coordination. This benefit amount is indexed in accordance with the terms and conditions described in this article retroactively to the date on which the coordination was applied, so as to reflect the benefit the participant would have received had it not been for the coordination with another income source.

6.9 REHABILITATION PROGRAM

The program is designed to foster the participant's reintegration into the workplace by providing the support necessary to both the participant and the employer. The main provisions of this program and working conditions conducive to its application are outlined in the Rehabilitation Program booklet. For further information, the participant must contact the employer's personnel department.

6.10 TERMINATION OF BENEFITS

Disability benefits terminate on the first of the following dates:

- a) the date on which the participant reaches age 65;
- b) the first date on which the disabled participant becomes eligible for:
 - a retirement pension without actuarial reduction calculated with 35 credited years of service for calculation purposes under the employer's retirement pension plan (e.g.: PPMP, TPP, CSSP, RPSO) or 32 credited years of service (PPPOCS);
 - or
 - a total benefit within the meaning of the PPCT corresponding to 70% of the average pensionable salary on the basis of which the pension under this plan is calculated;
 - or
 - a retirement pension with actuarial reduction, the amount of which corresponds to a retirement pension without actuarial reduction, calculated with 35 credited years of service for calculation purposes under the employer's retirement pension plan or 32 credited years of service (PPPOCS);
- c) the date of full retirement or full early retirement;
- d) the date on which total disability terminates.

Contributions to the employer's pension plan, if applicable, terminate on the date stipulated above, but not later than the date on which the participant actually receives a disability or retirement pension under the employer's pension plan.

6.11 RIGHT OF APPEAL

Two types of decisions can be contested:

- SSQ's refusal to recognize a disability condition;
- the tasks established for the rehabilitation job.

6.11.1 Objection to SSQ's refusal to recognize a disability condition

The participant or the employer, provided the participant agrees, may jointly or separately object to SSQ's decision not to recognize, or to cease recognizing, as of the 105th week, the participant's disability condition.

To avoid a lengthy and costly procedure, the government, the manager associations and SSQ have agreed to set up a medical arbitration tribunal

to settle such disputes.

In consideration of SSQ's obligation to abide by the decision of the medical arbitration tribunal, the participant must apply to the medical arbitration tribunal in writing and as such refrain from any further legal recourse to the civil courts or any other tribunal.

To submit an argument to the medical arbitration tribunal, the participant or the employer must provide SSQ with a notice in writing within 90 days:

- of the date SSQ's decision comes into force, if the decision is made before the end of the first 104 weeks of disability;

or

- of the date of SSQ's decision, if the decision is rendered after the first 104 weeks of disability.

The participant must send a copy of the contestation documents to the employer.

6.11.2 Objection to tasks established for the rehabilitation job

The sectoral committee is the first to intervene in this type of objection as well as in the case of temporary assignments (lasting for a maximum of one year).

If the participant does not obtain a satisfactory solution at this stage, the working conditions provide for a recourse mechanism whose decision for settling disputes is executory.

6.12 EXCLUSIONS

No benefits are payable for any period of disability resulting from self-inflicted illness or injuries, active participation in a riot, insurrection or criminal acts, or active duty in the armed forces or resulting directly or indirectly from a war or civil war, whether declared or not. This exclusion does not apply to an insured already present in a foreign country at the time war or acts of war break out. However, if the Government of Canada then recommends leaving the country, the insured must, to remain covered, take the necessary measures to leave the country as soon as possible;

This plan does not cover any period of disability during which the participant is not receiving regular care from a physician, except in the case that the participant's condition is deemed stable, and is attested to by a physician to the satisfaction of SSQ.

7- **COMPULSORY ADDITIONAL LONG TERM DISABILITY INSURANCE PLAN (CAP)**

This benefit plan provides supplementary income that complements, in part, the income received from rehabilitation employment.

A brief description of this plan and the main conditions pertaining to it are presented below:

7.1 **ELIGIBILITY FOR BENEFITS**

The participant is entitled to CAP benefits:

- if he meets the definition of disability under the employer's short term disability insurance plan; or
- after the first 104 weeks of disability, if he does not qualify or no longer qualifies under the definition of total disability provided for under the compulsory basic long term disability insurance plan.

In addition, he must:

- have successfully completed a rehabilitation program; or
- be in the process of completing a rehabilitation program; or
- not require rehabilitation, according to the evaluation report of his rehabilitation needs;

and

- occupy the rehabilitation position offered by the employer and approved by SSQ; or
- be temporarily assigned to a position for a period not greater than 12 months.

7.2 **BENEFITS**

The CAP benefits are equivalent to 95% of the participant's gross earnings at the beginning of the disability less the rehabilitation employment or temporary assignment earnings.

When the participant is employed on a gradual basis, the benefit amount is pro rated to the remunerated portion of the rehabilitation employment in contrast to full-time.

At no time may the CAP benefits exceed \$30,000 per year.

Note : **Earnings at the beginning of the disability and CAP benefits are not subject to the indexation clause indicated in Section 6.8.**

The rehabilitation or temporary assignment earnings are defined as being the higher of:

- i) an amount equal to the benefits that would be payable under the Compulsory Basic Long Term Disability Insurance Plan (annual maximum of \$58,000);

- ii) the rehabilitation employment or temporary assignment earnings on the basis of the normal work period at the beginning of the disability.

The benefits provided for under this plan may at no time however begin before a period of 104 weeks has elapsed since the beginning of the disability.

7.3 PAYMENT OF BENEFITS

When the participant qualifies for CAP benefits, they are paid during each of the following periods:

- a) when the participant has completed his rehabilitation plan, the period during which he is permanently employed in the rehabilitation position offered by the employer and approved by SSQ;
- b) during the gradual return to work period provided for in the rehabilitation plan approved by SSQ;
- c) the period during which the participant is employed in a temporary assignment while awaiting a rehabilitation position for a period not exceeding 12 months.

7.4 TERMINATION OF BENEFITS

CAP benefits terminate on the first of the following dates:

- a) the date on which the participant reaches age 65;
- b) the first date on which the disabled participant becomes eligible for:
 - a retirement pension without actuarial reduction calculated with 35 credited years of service for calculation purposes under the employer's retirement pension plan (e.g.: PPMP, TPP, CSSP, RPSO) or 32 credited years of service (PPPOCS);or
 - a total benefit within the meaning of the PPCT corresponding to 70% of the average pensionable salary on the basis of which the pension under this plan is calculated;or
 - a retirement pension with actuarial reduction, the amount of which corresponds to a retirement pension without actuarial reduction, calculated with 35 credited years of service for calculation purposes under the employer's retirement pension plan or 32 credited years of service (PPPOCS);
- c) the retirement date;
- d) date on which the participant completes a temporary assignment period of 12 months and still does not have a rehabilitation position approved by SSQ on this date. In such a case, SSQ informs the sectoral committee before ceasing payments;
- e) date on which ceases the rehabilitation position approved by SSQ or any subsequent rehabilitation position that follows with no period of interruption;

- f) the date when payable CAP benefits are less than 5% of the participant's earnings at the beginning of his disability.

7.5 PENSION PLAN CONTRIBUTION

CAP benefits are considered eligible earnings under the pension plan. Thus, the participant's contributions are deducted from the CAP benefits. SSQ assumes the employer's contributions, which are equal to those of the participant.

7.6 PREMIUM FOR THE SURVIVOR'S PENSION PLAN

SSQ assumes the premium for the survivor's pension plan.

7.7 LIFE INSURANCE AND SURVIVOR'S PENSION BENEFITS

In the event of death, CAP benefits are included in the calculation of earnings used to establish the overall amount of life insurance and survivor's pension benefits.

7.8 EXCLUSION

No benefits are payable for any period of disability resulting from self-inflicted illness or injuries, active participation in a riot, insurrection or criminal acts, or active duty in the armed forces or resulting directly or indirectly from a war or civil war, whether declared or not.

8- HOW TO SUBMIT A CLAIM

8.1 HOSPITAL EXPENSES

For hospital expenses incurred in Quebec, present your SSQ Card at the hospital.

8.2 PRESCRIPTION DRUG EXPENSES

There are two ways to forward your prescription drug claims to SSQ:

8.2.1 The SSQ Card

We wish to specify that only prescription drug expenses can be forwarded to SSQ via the electronic claims transmission system.

Upon presentation of your SSQ Card, your pharmacist will immediately validate whether the drug is eligible for reimbursement.

a) Eligible drugs

You pay your pharmacist the portion of the cost that is not reimbursed by your plan. SSQ reimburses the insured portion directly to the pharmacist. You have nothing else to do. The pharmacist is required to charge you the standard price, namely the same price paid by all other customers.

b) Non-eligible drugs

If the drug purchased is not eligible for reimbursement, the pharmacist will also give you a receipt with different messages, for example:

| Indication | Meaning |
|---|--|
| "Drug not covered" | Request for reimbursement refused, since the drug is not covered under the drug benefit. |
| "Maximum duration of treatment 90 days" | The quantity of drugs purchased cannot exceed a treatment period of 90 days. However, if for specific reasons your prescription exceeds a treatment period of 90 days, submit your claim, along with an explanatory note, directly to SSQ. |
| "Submit to Insurer" | The drug cannot be processed by using the SSQ Card but could be eligible for reimbursement. Example: If the prescription must be prepared by the pharmacist (magistral prescription). |
| "Exception drugs" | Drugs for which prior authorization must be obtained from SSQ (<i>see Section 2.2.1</i>). |

c) First use

If you have Family or Single-Parent coverage status, when you first use your SSQ Card for a member of your family, the pharmacist must complete the file by entering the first name and date of birth of the insured. Please provide your pharmacist with this information, if it has not already been entered in the system. This information remains confidential. As proof of age may be required by the pharmacist, you may wish to present the insured's RAMQ health insurance card.

d) Dependent children: full-time students aged 18 to 25, inclusive

Drug expenses for dependent children aged 18 to 25, inclusive, are covered upon presentation of a declaration of school attendance (*see Section 1.5.2*).

8.2.2 By mail

If you are unable to use your SSQ Card (lost, non-participating pharmacist, etc.), submit your claim using the claim form.

You can also print a personalized claim form from our **Customer Centre** Web site. For more information about our online services, refer to *Section 10* of this booklet.

To be eligible for reimbursement, all receipts and invoices must be presented within 12 months of the date expenses were incurred.

The pharmacist's invoice must be duly paid and show the participant's name, the patient's name, the number and date of the medical prescription, the physician's name, the drug name and quantity.

Where permitted by law, drugs supplied by a physician are also eligible for reimbursement upon submission of receipts indicating the drug name and quantity.

8.3 OTHER ACCIDENT AND HEALTH INSURANCE EXPENSES

The insured must file claims for all other eligible expenses directly with SSQ.

Most accident and health insurance expenses claims may be submitted online via the **Customer Centre** Web site at customer-centre.ssq.ca. You may also submit your claim with your smartphone using the SSQ Mobile Services application.

You can also submit the original of your receipts and paid invoices. However, receipts and invoices will not be returned, you may wish to keep copies. In order to facilitate the processing of your claims, we suggest you submit your receipts and paid invoices once every three (3) months.

To be eligible for reimbursement, all receipts and invoices, including for prescription drug expenses, must be presented within 12 months of the date expenses were incurred. Please note that the use of the SSQ Card for drug purchases ensures that receipts and invoices are submitted on time.

Claims should be submitted to SSQ at the address below using the claim form. You will find a claim form attached to the claim summary sent with your last benefit payment. You can also print a personalized claim form

on the **Customer Centre** Web site. For more information about our online services, refer to *Section 10* of this booklet. Please indicate your contract number on all claims or any other correspondence sent to SSQ.

SSQ Insurance
2525 Laurier Blvd.
P.O. Box 10500, Stn. Ste-Foy
Quebec QC G1V 4H6

Direct Deposit of Accident and Health Insurance Benefits

Direct Deposit enables you to obtain reimbursement of your claims more quickly and eliminates any risk of loss or theft of your benefit cheques.

You can opt for Direct Deposit when registering on the **Customer Centre** Web site. When registering, be sure to have your SSQ Card to hand, as well as a personal cheque showing your bank account number. For more information about our online services and how to register for Direct Deposit, refer to *Section 10* of this booklet.

If you would like to register for Direct Deposit but do not have access to the Internet, or if you require assistance in any way, contact SSQ Customer Service at one of the numbers provided on the back of this booklet.

8.4 HOSPITAL OR MEDICAL EXPENSES RELATED TO A WORKPLACE OR AUTOMOBILE ACCIDENT

In the event of a workplace or automobile accident, all ensuing medical or hospital expenses are payable by the CNESST or the SAAQ. Receipts and invoices should therefore be submitted to the CNESST or the SAAQ and not to SSQ.

8.5 TRAVEL INSURANCE AND TRIP CANCELLATION INSURANCE

8.5.1 Travel Insurance

Hospital and medical expenses payable under the Travel Insurance benefit are reimbursed only after assessment by government agencies (the RAMQ, the SAAQ, etc.), if applicable.

All expenses covered under this benefit may be claimed directly from CanAssistance upon presentation of supporting documents deemed satisfactory by SSQ (invoices, receipts, prescriptions, etc.).

8.5.2 Trip Cancellation Insurance

When submitting a claim, the insured must include the following supporting documents:

- a) unused travel tickets;
- b) official receipts for additional transportation expenses;
- c) receipts for ground travel and other expenses. Receipts must include contracts officially issued by a travel agent, accredited firm or booking platform indicating the non-refundable amounts in case of cancellation. Written proof that the insured has submitted a request for reimbursement of travel expenses, along with the results of such request, must be forwarded to SSQ;
- d) an official document certifying the reason for cancellation. If cancellation is due to medical reasons, the insured must provide a medical certificate issued by a legally authorized physician practising in the locality where the illness or accident occurred; the medical certificate must specify the complete diagnosis confirming the need to cancel, delay or interrupt the trip;
- e) a police report (in the event of delay due to a traffic accident or emergency road closure);
- f) an official weather report issued by the appropriate authorities;
- g) written proof issued by the official organizer of a commercial activity to the effect that an event is cancelled and indicating the specific reasons why;
- h) any other report required by SSQ in support of the insured's claim.

8.6 PARTICIPANT'S, SPOUSE'S AND DEPENDENT CHILDREN'S LIFE AND ACCIDENTAL DISMEMBERMENT (AD) INSURANCE

Claim forms for Life and Accidental Dismemberment Insurance are available directly from SSQ. These claims must be submitted within 90 days following the event.

8.7 LONG TERM DISABILITY INSURANCE

The employer must submit to SSQ the disability declaration at the start of the 7th month following the beginning of disability.

Claims for Long Term Disability Insurance benefits must be submitted to SSQ no later than 90 days following the date on which Long Term Disability Insurance benefits become payable (see section 6.3 *Duration of benefits*).

However, for your claim to be processed without delay, it is recommended that you submit your claim 90 days before the date on which you become eligible to Long Term Disability Insurance benefits.

8.8 PERSONAL INFORMATION AND INSURANCE FILE

Notice of constitution of a file

To maintain the confidentiality of personal information, SSQ will create an insurance and annuity file to hold information about your application for insurance or an annuity, along with information about any insurance claims you make.

Except for certain exceptions stipulated by law, access to this file will be restricted to employees or agents who are responsible for underwriting, investigations and claims, and any other person you may authorize. Your file will be kept in SSQ's offices in Quebec.

You have the right to consult the personal information held in your file and, if necessary, have this information rectified free of charge by submitting a request in writing to the address specified in *Section 8.3*. However, SSQ may charge fees for transcribing, reproducing or sending this information. The person making the request will be informed beforehand of the approximate amount that will be charged.

Legal Agents and Service Providers

SSQ may exchange information of a personal and confidential nature with its reinsurers, legal agents and service providers only for the purpose of allowing them to carry out the tasks SSQ asks of them, including processing most prescription drug and travel insurance benefit claims. SSQ's legal agents and service providers must comply with SSQ's Personal Information Protection Policy.

When enrolling in a group insurance plan and also when making a claim (e.g. using the prescription drug insurance card), the participant consents that the insurer and its legal agents and service providers may use their personal information for the purposes mentioned above.

It is understood that not giving this consent compromises the management of the insurance.

For more information, consult the SSQ Personal Information Protection Policy available at ssq.ca.

Available information on your group insurance plan

If the contract has been modified since the production date of this booklet, there may be wording differences between the booklet and the policy. If so, the policy wording will prevail. The participant is thus entitled to consult the policy and obtain a copy thereof by submitting a request for access to information to the Secrétariat du Conseil du trésor. The procedure is available on the Secrétariat du Conseil du trésor's Web site.

9- INSURANCE PLAN FOR RETIRED MANAGEMENT PERSONNEL

9.1 ELIGIBILITY

Any member of the management personnel of the Quebec public and parapublic sectors who, at the time his duties cease, is eligible for an immediate retirement pension, with or without actuarial reduction, in accordance with the retirement plan to which his employer contributes, and who participates in the group insurance plan for management personnel.

9.2 AVAILABLE PLANS

9.2.1 Retirees under age 65

- a) the insured must choose either the Basic or Expanded Accident and Health Insurance Plan, unless he is exempted from coverage (*Section 1.3*);
- b) the insured may, in addition, choose the Life Insurance Plan (*Section 4*). If the insured chooses the Expanded Accident and Health Insurance Plan upon retirement, he can reduce his coverage to the Basic Plan at any time before his 65th birthday. However, the choice to reduce to the Basic Plan is irrevocable and the insured will no longer be able to be insured under the Expanded Plan, except on the day he reaches age 65.

9.2.2 Retirees age 65 or over

- a) the insured may choose the Life Insurance and Basic or Expanded Accident and Health Insurance plans; or
- b) only the Basic or Expanded Accident and Health Insurance Plan; or
- c) only the Life Insurance Plan; or
- d) none of the above plans.

If the insured chooses the Basic Accident and Health Insurance Plan upon retirement, this decision is irrevocable.

9.3 APPLICATION PERIOD

Insurance for eligible individuals who submit their applications within the timeframe described below becomes effective on the date upon which they become eligible.

9.3.1 Accident and health insurance plan for retired management personnel under age 65

Individuals have 90 days following the date they become eligible for the accident and health insurance plan for retired management personnel to confirm their participation in the SSQ plan by completing the application form available at the end of this booklet.

A retiree under age 65 who does not file an application with SSQ for coverage under the retirees' accident and health insurance plan within 90 days following the date of eligibility forfeits any right to participate in the Expanded Accident and Health Insurance Plan thereafter, except on the day he reaches age 65. However, the retiree remains eligible to participate in the Basic Accident and Health Insurance Plan in accordance with the provisions specified above and coverage and premiums payable for basic accident and health insurance coverage are retroactive to the date of eligibility, up to a maximum of 12 months. Benefits for this period are also retroactively reimbursed, up to a maximum of 12 months.

Furthermore, the retiree has to pay the premium to the RAMQ for the period during which coverage was not yet in force at SSQ. Prescription drugs are not covered during this period. Participation in the Accident and Health Insurance Plan is mandatory under the Quebec's Act respecting prescription drug insurance.

9.3.2 Accident and health insurance plan for retired management personnel aged 65 or over

From age 65, participants may choose to maintain prescription drug insurance coverage with SSQ, or opt for coverage with the RAMQ. Individuals have **90 days** following the date they become eligible for the accident and health insurance plan for retired management personnel to confirm their participation in the SSQ plan by completing the application form available at the end of this booklet.

A retiree, aged 65 or over, who does not file an application with SSQ for coverage under the accident and health insurance plan within 90 days following the date of eligibility forfeits any right to participate in the plan thereafter.

9.3.3 Life insurance plan

Individuals have **90 days** following the date they become eligible for the life insurance plan for retired management personnel to confirm their participation in the SSQ plan by completing the application form available at the end of this booklet.

A retiree who fails to file an application for the retired management personnel life insurance plan with SSQ within 90 days following the date of eligibility forfeits any right to participate in the plan thereafter.

Once you **change from the employee group insurance plan to the retiree group insurance plan**, all the information in your file at the time will be transferred to your new file under the retiree group insurance plan. Documents already provided to SSQ, such as the declaration of school attendance for your dependent children or the form for exception drugs, if applicable, will not need to be submitted again. SSQ keeps track of the reimbursement in health insurance expenses, which means that the amounts you have incurred since January 1 will be included under your new plan. During this transfer of information, the amount of claims paid by SSQ for each type of treatment is also compiled and included under your new plan. However, for any given type of treatment, it is possible to ask that SSQ reset your counter to zero. As such, you will be entitled to the maximum reimbursement stipulated under the retiree group insurance plan.

For a complete description of the plans available for retired management personnel, please consult the booklet entitled: **Group Insurance Plans offered to Retired Management Personnel of the Quebec Public and Parapublic Sectors**, which you may obtain by contacting SSQ's Customer Service.

10- SSQ'S ONLINE SERVICES

10.1 CUSTOMER CENTRE

This handy online service gives you fast, secure and confidential access to your insurance file at any time. Here are just a few of the operations you'll be able to carry out:

- Register for Direct Deposit of your Accident and Health Insurance benefits;
- View your electronic claim statements;
- Print personalized claim forms;
- Order tax receipts for incurred medical expenses;
- Print a temporary SSQ Card if you lose or misplace your existing card;
- Change your address;
- View the coverage included as part of your contract;
- Submit your claim online and get a reimbursement in your account within 48 hours with Direct Deposit (for most benefits);
- Change beneficiary designation online;
- Check coverage for medical expenses, including for prescription drugs;
- Estimate reimbursement amounts;
- Get your proof of travel insurance.

To register for Access and take advantage of our handy online services, visit our **Customer Centre** Web site at customer-centre.ssq.ca Just follow a few simple online instructions designed to guide you through the registration process. Please note that documents in your file are kept for a period of 12 months.

If you require assistance, contact SSQ Customer Service, Monday to Friday from 8:00 a.m. to 8:00 p.m. at one of the numbers on the back of the booklet.

10.2 SSQ MOBILE SERVICES

If you have a smart phone* you can download for free the SSQ Mobile Services application at www.ssq.ca/mobile.

The application enables you to carry out the same operations as you would on the Customer Centre Web site.

* Now available on Apple and Android platforms.

11- GOOD THINGS TO KNOW

- If the health care professional who is treating you recommends a particular treatment and you're not sure whether this treatment is covered, call SSQ.
- You can check at any time the eligibility of your expenses using the simulation tool available via the **Customer Centre** at customer-centre.ssq.ca or directly on the mobile application.
- For income tax purposes, keep the claim summary that is attached to your reimbursement cheque. When you prepare your income tax return, add up all of your claim summaries to determine the total amount of medical expenses that could increase your tax credits. If you are registered to use SSQ's **Customer Centre** Web site, you can submit a request on line for a tax receipt that includes the amounts of claims made and the amounts reimbursed under your contract. You can include the receipt with your income tax return.
- For income tax purposes, only your employer can provide you with details of the total premiums you paid for your group insurance coverage. Contact your group plan administrator for more information.
- Did you know that if you are covered under two group insurance plans, you may be able to obtain full reimbursement of your expenses if they are eligible under both plans? You should first submit your claim to the insurer who covers your plan with your main employer. When you receive your claim summary, you can send a copy of it, along with copies of your receipts and paid invoices, to submit a claim for the difference to your other insurer.
- Misplaced your claim form? Simply write your name and Insurance Certificate number on a separate sheet of paper and attach it to your claim. Your claim will be processed in the usual manner. You can also print a personalized claim form from the **Customer Centre** Web site at customer-centre.ssq.ca.
- Always use your SSQ Card at the pharmacy and you will immediately know whether your prescription drugs are eligible for reimbursement.
- If you experience health problems while travelling, don't hesitate to contact CanAssistance at one of the numbers on the back of your SSQ Card.
- The most recent documents (booklet, card, etc.) are available on the **Customer Centre Web site** at customer-centre.ssq.ca

12- RATES

BI-WEEKLY RATES FROM JANUARY 1 TO DECEMBER 31, 2022

| Plan | Individual | | | Single-parent | | | Family | | | | | |
|--|--|----------|--------------------------------|---------------|----------|----------|--------------------------------|----------|----------|----------|--------------------------------|----------|
| | Employer | Employee | Premium holiday ⁽¹⁾ | Total | Employer | Employee | Premium holiday ⁽¹⁾ | Total | Employer | Employee | Premium holiday ⁽¹⁾ | Total |
| | Compulsory Basic Accident and Health Insurance Plan | | | | | | | | | | | |
| Under age 65 | \$26.06 | \$48.95 | \$2.58 | \$77.59 | \$27.48 | \$51.61 | \$2.72 | \$81.81 | \$52.67 | \$98.94 | \$5.21 | \$156.82 |
| Age 65 or over ⁽²⁾ | \$26.06 | \$25.23 | \$1.33 | \$52.62 | \$27.48 | \$27.89 | \$1.47 | \$56.84 | \$52.67 | \$51.51 | \$2.71 | \$106.89 |
| Additional premium for participants age 65 and over ⁽³⁾ | \$ - | \$106.61 | \$ - | \$106.61 | \$ - | \$123.10 | \$ - | \$123.10 | \$ - | \$229.34 | \$ - | \$229.34 |

Premiums do not include the 9% provincial sales tax.

⁽¹⁾ Please note that a **premium holiday** of 5% is granted to the employee for the mandatory Accident and Health Insurance.

⁽²⁾ All premium rate changes applicable subsequent to an age change are effective as of the first day of the pay period coinciding with or following the age change.

⁽³⁾ Additional premiums paid by participants age 65 or over, starting as of the first day of the pay period coinciding with or following their 65th birthday, if opting for prescription drug coverage under the group insurance plan rather than under the RAMQ plan.

| Plan | Employer | Employee | Premium holiday | Total |
|--|----------|---------------|-----------------|---------------|
| Compulsory Basic Life Insurance Plan (as % of salary) | | | | |
| - Participant's (50% of annual earnings) | -% | 0.0666% | 0.0000% | 0.0666% |
| - Spouse's and Dependent Children's (\$17,200 for the spouse and \$5,000/child) | -% | 0.018% | 0.0000% | 0.018% |
| - Accidental Dismemberment | -% | 0.006% | 0.0000% | 0.006% |
| TOTAL | -% | 0.090% | 0.000% | 0.090% |
| Compulsory Basic Long Term Disability Insurance Plan (as % of salary) | 0.741% | -% | -% | 0.741% |
| 65% of gross monthly earnings as of the 105 th week of total disability | | | | |
| Compulsory Additional Long Term Disability Insurance Plan (as % of salary) | 0.015% | -% | -% | 0.015% |

Premiums do not include the 9% provincial sales tax.

| Plan | Rate per \$1,000 of coverage | Rate as % of salary ⁽¹⁾ | Rate per \$1,000 of coverage | Rate as % of salary ⁽¹⁾ |
|--|--|-------------------------------------|--|-------------------------------------|
| | Male / Smoker ⁽²⁾⁽³⁾ | Male / Non-smoker ⁽²⁾⁽³⁾ | Male / Non-smoker ⁽²⁾⁽³⁾ | Male / Non-smoker ⁽²⁾⁽³⁾ |
| Participant's and Spouse's Optional Life Insurance Plan | | | | |
| Age 34 and under | \$0.021 | 0.055% | \$0.011 | 0.029% |
| Age 35 to 39 | \$0.035 | 0.091% | \$0.015 | 0.039% |
| Age 40 to 44 | \$0.052 | 0.136% | \$0.025 | 0.065% |
| Age 45 to 49 | \$0.085 | 0.222% | \$0.044 | 0.115% |
| Age 50 to 54 | \$0.142 | 0.370% | \$0.083 | 0.217% |
| Age 55 or over | \$0.223 | 0.582% | \$0.151 | 0.394% |
| | Female / Smoker ⁽²⁾⁽³⁾ | | Female / Non-Smoker ⁽²⁾⁽³⁾ | |
| Age 34 and under | \$0.015 | 0.039% | \$0.003 | 0.008% |
| Age 35 to 39 | \$0.025 | 0.065% | \$0.013 | 0.034% |
| Age 40 to 44 | \$0.045 | 0.117% | \$0.021 | 0.055% |
| Age 45 to 49 | \$0.066 | 0.172% | \$0.035 | 0.091% |
| Age 50 to 54 | \$0.108 | 0.282% | \$0.059 | 0.154% |
| Age 55 or over | \$0.153 | 0.399% | \$0.109 | 0.284% |

Premiums do not include the 9% provincial sales tax.

⁽¹⁾ The rates as percentage of the salary apply only to the Participant's Optional Life Insurance.

⁽²⁾ Rates for Spouse's Optional Life Insurance are determined based on the spouse's gender and smoking habits (smoker or non-smoker) but on the participant's age.

⁽³⁾ All premium rate changes applicable subsequent to an age change are effective as of January 1 coinciding with or following the age change.

Composition of the Intersectorial Parity Committee (IPC):

| Government Representatives | Management Association Representatives |
|--|---|
| Co-chairperson | Co-chairperson |
| Secretary of committee | |
| Actuary | 1 representative for retirees |
| Public Service and Treasury Board | |
| 1 representative | 1 representative |
| Health and Social Services | |
| 2 representatives | 3 representatives |
| Education | |
| 3 representatives | 2 representatives |

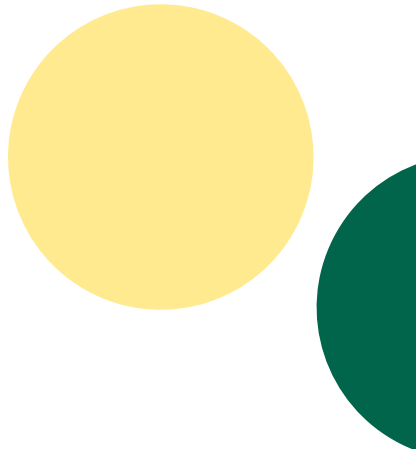
To contact the members of the Intersectorial Parity Committee

Secretariat of the Intersectorial Parity Committee
875 Grande Allée East, Suite 100
Quebec (Quebec) G1R 5R8

A friendly tip from you committee

Save on your medication costs by shopping around!

By shopping around for your medication, you'll spend less and have a positive impact on your group plan's premium cost. It's a fact that the differences in cost from one pharmacy to another can be significant. For this reason we recommend that you get cost estimates on your medication at more than one pharmacy. Then you'll be in a better position to choose the quality of service and price that's right for you.



Contact us

2525, Laurier Boulevard
P.O. Box 10500, Stn Ste-Foy
Quebec QC G1V 4H6

Quebec City area: 418 651-6962
Other areas: 1 888 833-6962

ssq.ca

Please keep this booklet for future reference.